HEALTH CARE SERVICES FOR AGING VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

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CONTENTS

April 13, 1989

	Page
Health Care Services for Aging Veterans	1

OPENING STATEMENT

Chairman Evans	1
Hon. Bob Stump	2

WITNESSES

Adelman, Richard C., Ph.D., Chairman, Geriatrics and Gerontology Advisory Committee, Department of Veterans Affairs	9
Prepared statement of Dr. Adelman	47
Cullinan, Dennis M., assistant director, National Legislative Service, Veterans of Foreign Wars of the U.S.	25
Prepared statement of the Mr. Cullinan	64
Florio, James J., a Representative in Congress from the State of New Jersey	3
Prepared statement of Congressman Florio	38
Gorman, David W., assistant national legislative director, Disabled American Veterans	28
Prepared statement of the Mr. Gorman	72
Mansfield, Gordon, associate executive director of government relations, Paralyzed Veterans of America	30
Prepared statement of the Mr. Mansfield	91
Sommer, John F., Jr., director, National Veterans Affairs and Rehabilitation Commission, the American Legion	18
Prepared statement of Mr. Sommer	54
Stone, Howard L., chief counsel to the Department of Illinois AMVETS	19
Prepared statement of Mr. Stone	63
Svanborg, Alvar, M.D., Ph.D., Professor of Medicine, chief, geriatric medicine section, clinical director of research, gerontology center, University of Illinois at Chicago	20
Prepared statement of the Dr. Svanborg	58
Wanamaker, Cmdr. John F., USN (ret.), deputy director of legislative affairs, the Retired Officers Association	26
Prepared statement of the Commander Wanamaker	67
Winship, Daniel H., M.D., Associate Deputy Chief Medical Director, Department of Veterans Affairs, accompanied by Ralph J. Ibson, deputy assistant general counsel; Thomas T. Yoshikawa, M.D., assistant chief medical director for geriatrics and extended care	7
Prepared statement of Dr. Winship	40
Woosley, Noel C., national service director, AMVETS	19

MATERIAL SUBMITTED FOR THE RECORD

Statements:	
Hon. Douglas Applegate	35
Hon. Craig James	37
Hon. Cliff Stearns	46

Page

Written committee questions and their response:
Hon. Lane Evans to Department of Veterans Affairs 97
Hon. Lane Evans to Dr. Richard Adelman, chairman, Gerontology Advisory Committee 111
Hon. Bob Stump to Department of Veterans Affairs 110

HEALTH CARE SERVICES FOR AGING VETERANS

Thursday, April 13, 1989

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:12 a.m., in room 340, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee), presiding.

Present: Representatives Evans, Stump, James, Florio, Stearns, Kennedy.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order. I'm sorry about the brief delay. We thought we were going to have a Journal vote. We normally like to start hearings on time in this committee.

Welcome to the first Oversight and Investigations Subcommittee hearing of the 101st Congress. I want to welcome back each returning member of the subcommittee and extend a welcome to the new members of the subcommittee, Joe Kennedy, Bob Smith, Craig James, and Cliff Stearns.

Today we will examine a number of issues which are important to all veterans, and especially to the growing population of older veterans. These issues include: the types, mix and amount of health care which is expected to be needed by the aging veteran population; the plans, strategy and readiness of the Department of Veterans Affairs to deliver that care; and the resources which will be needed.

In addition, we will review the Geriatric Research, Education and Clinical Center program of the Department of Veterans Affairs. We will explore the purpose and goals, record, and proposed future course of the GRECC program.

The issue of providing care to an aging veteran population is not a new one to the Department of Veterans Affairs. Sixteen years ago, in 1973, the initial development of the GRECC program gave recognition to the need for specialized clinical care, research and education to improve the care given to aging veterans. Later, in 1977, the VA issued a report entitled "The Aging Veteran: Present and Future Medical Needs." In 1982, the VA commissioned Louis Harris and Associates to conduct a national survey of the needs, resources and expectations of veterans aged 55 and older. In 1984, a report entitled "Caring for the Older Veteran" was issued by the

VA, a part of the Department's continuing examination of issues related to the care of older veterans.

More recently, the new Secretary, Ed Derwinski, was asked how the Department of Veterans Affairs would respond to the rapidly growing aging veterans population. He responded by saying, "I told our people to make sure they've dusted off all their plans and . . . to be ready for it. We don't need to study it . . . we don't need to go back to the drawing board for new plans. They'd better have some good ones ready to go. If they don't they've been derelict in their duties."

At the beginning of this decade, there were 3 million veterans who were 65 or older. They comprised about 10.5 percent of the veteran population. Next year, in 1990, older veterans will number between 7 and 8 million and will constitute more than 25 percent of the veteran population. Demographers tell us that this trend will continue and that in the year 2020 older veterans are expected to account for 44 percent of the veteran population. This is a senior veteran imperative.

In one sense, today we will examine the results of 15 years of preparation and learn if the Department has good plans which are ready to go or if there has been, in the words of Secretary Derwinski, dereliction of duty. The subcommittee wants to understand, for example, if the closure of nursing home beds from coast to coast and the growing number of veterans waiting for nursing home care is a temporary aberration or a preview of the future.

This is a general oversight hearing. We expect the results will be useful in their own right and to others who may also consider these issues.

I am happy now to recognize Congressman Bob Stump, the ranking Republican member of both the full committee and the subcommittee, for any comments he would care to make. I am pleased that he has chosen to continue to serve as the ranking member of this subcommittee, and I look forward to his continuing constructive and important contributions.

Following his comments, we will recognize any other members.

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman.

We all know that our veteran population is aging, and I think the Department of Veteran Affairs and our committee must keep this in mind as we address overall health care needs. I look forward to hearing from today's witnesses about what has been done and what needs to be done to assure the availability of care for the specific needs of our older veterans.

Mr. Chairman, I would like to mention that Mr. Smith is down the hall in the Memorial Affairs Subcommittee meeting and that I was responsible for Mr. James walking over to cast a vote he thought he was going to do. So I apologize for that. He should be back very shortly.

Mr. EVANS. Thank you very much.

Our colleague Doug Applegate is unable to be here. His prepared statement will be included in its entirety in the hearing record, if there is no objection.

[The statement of Congressman Applegate appears at p. 35.]

Mr. EVANS. Our first witness is our esteemed colleague James Florio. An active, valued, and contributing member of the subcommittee, he has distinguished himself by tireless work on behalf of veterans. He also serves as a valued member of the House Select Committee on Aging. Last September, he chaired a field hearing on the health care needs of aging veterans, which was conducted by the Health and Long-Term Care Subcommittee of the Aging Committee. We hope he will share with us today some of the insights he has gained from that hearing.

We want to recognize him and tell him that we will include his entire statement in the record. Thanks for your leadership on this issue, Jim.

STATEMENT OF HON. JAMES J. FLORIO

Mr. FLORIO. Thank you very much, Mr. Chairman. I am pleased to be here. And thank you for the courtesy of affording me the opportunity to speak very briefly at the beginning of this meeting.

I have another hearing that I chair, and in a sense it is this responsibility that I think prepares me for helping or contributing to this committee's deliberations as well as the unique perspective of having some other committee assignments that cross over into the area that this committee is primarily charged with. I serve as the chairman of a subcommittee of the Energy and Commerce Committee that deals with insurance in general and health insurance in particular. Likewise, I serve as the chairman of a subcommittee of the Select Committee on Aging. In those capacities, as well as being a member of the Veterans Affairs Committee, I have looked at how all of the interactions between insurance, health insurance, aging and veterans all come to play, and quite frankly it is not totally a pleasurable picture that comes out.

I have a statement for the record and I would like to just briefly go through a portion of because I think it can share with you some insights that I think are very important for this committee to have.

This past September I brought the House Aging Subcommittee on Health and Long-term Care to New Jersey to take testimony from veterans in my district who are a part of this group of aging veterans that we are talking about today. Mr. Chairman, unfortunately, we had no difficulty in finding veterans and their families only too willing to talk about the shortcomings of veterans' facilities in dealing with the needs that they face.

I heard compelling testimony from a number of veterans. One, in particular, a Navy veteran who served his country for 30 years, was instructive. When he turned to the VA for his extensive medical problems, in his words, he lost faith in the VA health-care system. When he needed immediate hospitalization for a possible tumor in his kidney, he was told by the VA that he would have to go to the nearest VA hospital, in Philadelphia, an hour and a half from his home. When he got to the hospital at approximately 3:30 in the afternoon, he was told that he would have to see a urologist, and the urologist was not available. He was sent home again in a bleeding condition. When he saw the urologist the next day, again

in Philadelphia, he was told that he would have to go home and come back in one more week for tests.

Two days later, because of the gravity of the situation, he checked into the nearest civilian hospital for emergency surgery after getting approval from the VA. But his troubles were not over. The night before his surgery, this veteran who had served his country for 30 years was transferred by ambulance, still bleeding, back to the VA hospital that had sent him home. However, he was sent to have more tests done at another private hospital. Since transportation to that hospital was not forthcoming from the VA, our veteran took a taxi, in his bathrobe.

Mr. Chairman, my constituent was operated on at the VA Hospital one month after he had started bleeding and a 5½ pound tumor was removed. My constituent did not tell his country to wait around for a month when he was called to service in World War II. This type of treatment is clearly unacceptable.

There is no end to the problems that elderly veterans are encountering within the VA system. Just last week, I held a hearing of my Subcommittee on Commerce, Consumer Protection, and Competitiveness on the "Medi-gap" policies our seniors in general are buying to protect them from high cost of health care. Medi-gap, of course, is the supplementary insurance policies that people buy to supplement the deficiencies in the medicare system. One of my witnesses was another World War II veteran who had become a victim of these Medi-gap policies. For him the closest VA facility that he would go to was in Wilmington, Delaware. Keep in mind that I represent a district in Southern New Jersey.

When he had a minor heart attack sometime ago he checked into the closest private hospital. When he learned that it would cost him $320 per day he checked right out and went home, because he just did not have that type of money. Because he failed to get adequate medical care he suffered a massive heart attack a short period of time later on. This time he was taken to the Wilmington VA Hospital where his care was, appropriately, cost free.

What disturbed me about this situation was that this veteran did not even know that he could get free medical care because of his situation. Because he didn't know this, he went out and purchased a very expensive and unnecessary Medi-gap policy, as so many of our seniors are doing nowadays, to pay for whatever costs medicare would not cover.

Mr. Chairman, admittedly these are two anecdotes, two real-life situations, but I am becoming more and more convinced that they illustrate the needs of the aging veterans and these veterans are facing these situations more and more frequently. Make no mistake about it, America in general is growing grayer. By the year 2000, the number of veterans 65 years or older is expected to triple to some 9 million such veterans. Studies show that we would have to open a 200-bed nursing home every day between now and the year 2000 in order to meet the need that is evolving. In terms of regular acute care hospital beds, we will need a 25 percent increase. We need more resources for home care, for respite care, for nursing home and for acute care. Instead, as we know, the VA is cutting back, with sometimes disastrous results.

Not long ago this committee released a troubling report showing that not only is the VA failing to increase service, but it actually has put 13,000 beds out of service across the Nation. My area has been especially hard hit. Over a year ago a man died at Coatesville, Pennsylvania, the psychiatric hospital. The facility there wasn't sufficiently trained and there weren't sufficient numbers of people to provide for him being cared for correctly, and as a result of mismatching of prescriptions with patients, the individual, in fact, died.

This facility, incidentally, over that time has had further staff reductions. The facility has more than half of its beds not being used because of staff deficiencies. This comes at a time when there is a waiting list to get into the facility with half the beds not being used.

Beds available for veterans for health care at Lyons, in New Jersey, and at East Orange have been put out of service and off limits for lack of staff.

Let me conclude by saying that across this country 20,000 veterans each month are refused care. They are turned away because there is no room or, in some instances, there is not enough staff. For others, care comes only after long waits and long lines. I hope that when this hearing is finished we will have a better understanding of not only the problems of our senior vets, problems that they are facing, but that we will also face up to some of the needed solutions that are going to be required to deal with these problems. The veterans that I have in my district—I suspect this is the case across the country—are proud people, and they have a lot to be proud about. They put their lives on the line in many instances for their country. I don't think that it is too much to ask that in their advancing years we treat them with the dignity and the respect that are the very opposite of what it is I have just outlined and the instances that I know about. I think that is the prime mission of this committee in terms of developing facts, so that those facts can be translated to legislative committees to enact policies that will avoid this type of thing.

Let me express my appreciation for the opportunity to come and share some thoughts with you.

[The prepared statement of Congressman Florio appears at p. 38.]

Mr. EVANS. Thank you very much. We appreciate your testimony, and also your advocacy for New Jersey veterans. I know that you are probably hearing not only from individual veterans in your district, but from across the State, and probably from some of the Members of Congress as well, since you are an active member of this committee.

Have you heard, for that matter, from Members from eastern Pennsylvania, Delaware, and New Jersey that aren't on this committee?

Mr. FLORIO. The answer, Mr. Chairman, is yes, in a very active way. In our area, the Philadelphia media area carries actions, and therefore I get lots and lots of mail from people as far away as Coatesville, Pa. Delaware as well. Yes. The answer is we do hear from people far beyond the confines of just my legislative district.

Mr. EVANS. I think you know that this is, as you say, a nationwide problem. I wonder if you have any opinion about our recom-

mendation of $340 million for a supplemental appropriation and then additional monies in the next fiscal year. How far might this go to help veterans in New Jersey?

Mr. FLORIO. Well, it will certainly be helpful to reduce at least the emergency situation. As I said, the situation in Coatesville is totally inexcusable. It is a psychiatric hospital. People, by definition, who have problems there generally have serious problems. They are routinely turned away because the hospital keeps almost half of the beds that are there out of use because of the absence of staff. So the supplemental certainly would be of great value in that particular instance, and I suspect that this is not a unique situation.

Mr. EVANS. All right. Thank you.

Mr. Stump, any questions?

Mr. STUMP. I have no questions.

Mr. EVANS. Thank you for your time.

Mr. FLORIO. Thank you very much.

Mr. EVANS. The members of our first witness panel today are Dr. Daniel Winship, Mr. Ralph Ibson, Dr. Richard Adelman, and Dr. Thomas Yoshikawa. Will you all please come forward?

Dr. Winship is the Associate Deputy Chief Medical Director. He has participated in many hearings before this subcommittee, so many that I am afraid if I were to miss a meeting he would have a better attendance record than I do. He is accompanied by Mr. Ibson, the Deputy Assistant General Counsel, and it is also a pleasure to welcome him before the subcommittee once again.

Dr. Adelman serves as the Chairman of the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs. Additionally, he is the Director of the Institute of Gerontology at the University of Michigan, at Ann Arbor. The subcommittee is pleased to welcome him.

Dr. Thomas Yoshikawa has recently assumed the responsibilities of the Assistant Chief Medical Director for Geriatrics and Extended Care. Prior to his appointment, he served as a GRECC director, a clinician, a researcher, and educator. He is not presenting a prepared statement today, but we expect that he will make a significant contribution based on the wealth of his experience. I also understand that this is the first Congressional hearing in which he has participated, so we welcome you as well today.

Dr. Winship, you may proceed. And of course, your entire statement will be made a part of the record, without objection. If you would like to summarize from it, you will be allowed to.

STATEMENTS OF DANIEL H. WINSHIP, M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY RALPH J. IBSON, DEPUTY ASSISTANT GENERAL COUNSEL; RICHARD C. ADELMAN, PH.D., CHAIRMAN, GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE, DEPARTMENT OF VETERANS AFFAIRS; THOMAS T. YOSHIKAWA, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF DANIEL H. WINSHIP, M.D.

Dr. WINSHIP. Thank you, Mr. Chairman. First, I would like to mention that in the formal statement that we have presented there is a typographical error which I would like to correct because I think it is important. On page 2, we refer to 17 domiciliaries. The correct number should be 27 domiciliaries.

Mr. EVANS. Without objection, we will correct that in your prepared statement as a part of the record.

Dr. WINSHIP. Thank you, sir.

Mr. Chairman and members of the subcommittee, it is pleasure to appear before the subcommittee to discuss health care needs of aging veterans and the Department of Veterans Affairs extended care programs. Since you have already introduced the gentlemen at the table with me, I will not do that further.

The health care needs of aging veterans are not different from those of the aging population at large, except that at this time the aging veteran proportion is far higher than that of the general population. The compelling demographics of the aging veteran population are well-known to this subcommittee. Over the past 10 years, the number of aged veterans has doubled. The overall number of veterans in the United States will steadily decline from 1990 to the year 2020, from 27 million down to 17 million. Conversely, the number of aged veterans will continue to increase from slightly over 7 million to nearly 8 million over the same period, peaking in the year 2000 at nearly 9 million veterans.

As the veteran population ages, and although acute inpatient care is vital to elderly veterans, acute short-term medical episodes are overtaken increasingly by long-term care stays. The Va is a national leader in the delivery of long-term care, providing to eligible veterans a broad continuum of health care services. These programs range from the most intensive intervention, found in the nursing home care programs, to the least intensive, the community residential care home programs. At the most intensive level, medical and nursing services predominate. At the least intensive level, health-related and social support services become more essential.

Mr. Chairman, the VA has developed several alternatives to long-term care. These include Hospital-Based Home Care, Adult Day Health Care and Community Residential Care.

The Hospital-Based Home Care program employs an interdisciplinary team of VA staff to deliver primary medical care to homebound patients by providing professional care, supervision and instruction in nursing procedures and daily care.

Adult Day Health Care provides health maintenance and rehabilitative services to frail individuals in a congregate setting during daytime hours. This program is designed to provide an alternative

to unnecessary hospitalization and to delay premature hospital admission.

The Community Residential Care Home program provides room, board, and limited personal supervision, at the veteran's own expense, along with home visits by VA social workers and nurses and outpatient care for the veteran.

In fiscal year 1987, the VA also began implementation of an institutional respite care program. This program allows eligible veterans to receive inpatient hospital care for up to 30 days per calendar year in order to provide relief to the at-home caregiver.

The VA will continue to maintain a broad-based, active strategy to meet the long-term care needs of the aging veteran population. Critical elements of the VA's strategy include program growth, reliance on community and State home programs, converting hospital beds to nursing home beds, gradual expansion of noninstitutional programs, initiatives in community residential care, and community volunteer resources and geriatric assessment.

I would now like to turn to the VA's Geriatric Research, Education and Clinical Centers, or the GRECCS. The VA initiated a strategy in the early 1970s to focus attention on the aging veteran population by increasing the basic knowledge of aging, transmitting that knowledge to health care providers, and improving the quality of care to the aged.

The VA's GRECCs, Mr. Chairman, have become increasingly competitive in obtaining peer review funds from sources other than the VA. In fiscal year 1984, 58 percent of peer review dollars were non-VA monies, while the current percentage in the GRECCs is over 70 percent.

GRECC investigators are recognized nationally and internationally for their achievements. Their work directly influences the provision of care for elderly patients.

The GRECCs disseminate research, clinical care knowledge and other geriatric and gerontological information through continuing education activities and through the provision of training to Geriatric Fellows, residents, nurses and other associated health trainees. In addition to continuing education activities, the Centers' staff provide lectures, seminars, case conferences and teaching clinical rounds at their host VA medical centers and lectures and training at other VA medical centers and in the community.

One very important clinical achievement of the GRECCS has been the development of a geriatric evaluation and treatment program. Geriatric Evaluation Units have been found to be highly successful in improving patient care outcomes including decreased mortality, decreased discharge to nursing homes, lower rehospitalization rates, and a lower cost of care.

Finally, Mr. Chairman, the VA has been and will remain a leader in the provision of quality long-term care services to eligible veterans. The VA has developed a model continuum of care. We have sought and will continue to refine the balance between acute and long-term care as well as between hospital and nonhospital care. We are committed to efficiency in program operations. We will search and, when feasible, test appropriate new modalities of quality and cost-effective service delivery.

Mr. Chairman, this concludes my remarks. We will be pleased to answer any questions you or members of the subcommittee may have. Thank you.

[The prepared statement of Dr. Winship appears at p. 40.]

Mr. EVANS. Dr. Winship, thank you. We will first hear from Mr. Adelman before we ask questions.

STATEMENT OF RICHARD C. ADELMAN, PH.D.

Dr. ADELMAN. Mr. Chairman and distinguished members of the committee, my name is Dr. Richard Adelman. I am the director of the Institute of Gerontology at the University of Michigan, a recent past president of the Gerontological Society of America, and the current chairman of the congressionally established Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs.

More than 20 years of professional experience as a gerontologist have provided me with an intimate familiarity with the recent successes and missed opportunities of the Department of Veterans Affairs in providing care for the elderly. The success story of the past 20 years is, indeed, the congressionally established network of Geriatrics Research, Education and Clinical Centers commonly referred to by its acronym as the GRECCs. This network consists of 10 geographically dispersed, modestly funded model programs in geriatric patient care, education and research.

I participated in the selection of each of these GRECCs, and I have visited each of them subsequently at least once and several of them many times. One exciting example of their enormous impact on the health professions across the United States is the manner in which the GRECC leadership almost singlehandedly provoked the rapidly growing prominence of geriatric medicine throughout this Nation's medical schools, including that of my own institution, the University of Michigan.

Ironically and unfortunately, however, the Department of Veterans Affairs presently is not prepared to care for its rapidly growing population of aging veterans. The reason it is unprepared is the failure of central office to adopt the successful model programs of the GRECC by integrating them into the mainstream of activity throughout the national network of veterans hospitals. If it is the intent of Congress to arrange for the appropriate care of the rapidly growing population of aging veterans, then it will be necessary for Congress to mandate change in the Department of Veterans Affairs.

I respectfully recommend each of the following three changes:

Number one, empower the Assistant Chief Medical Director for Geriatrics and Extended Care with sufficient additional resources and authority to establish formal programs in geriatrics and long-term care at every veterans hospital.

Number two, instruct the Chief Medical Director to require and to provide the necessary resources for training in geriatrics at regionally convenient GRECCs by all service providers in the Department of Veterans Affairs.

And number three, increase the research budget in a manner specifically designed to encourage investigators of all kinds

throughout the veterans hospitals to apply their expertise to the more sophisticated understanding of aging.

Each of these recommendations is complex and requires immediate implementation with phasing to coincide with the availability of appropriately trained personnel, as elaborated upon in my written testimony. Each of these recommendations will be discussed in even greater detail in a meeting of the Geriatrics and Gerontology Advisory Committee here in this room on Tuesday morning, April 25. Each of these recommendations will be communicated officially within the next few weeks as part of a formal report by the committee to the Department of Veterans Affairs and to Congress.

I thank you for this opportunity to testify, and I shall be pleased to attempt to answer any questions.

[The prepared statement of Dr. Adelman appears at p. 47.]

Mr. EVANS. Thank you very much.

Dr. Winship, the Chief Medical Director, Dr. Gronvall, in answering a question before the Subcommittee on Hospitals and Health Care yesterday, stated that he calculated that during the first months of this fiscal year VA medical centers, including the outpatient clinics, have turned away some 25,000 eligible veterans for hospital care and in excess of 65,000 veterans for outpatient care.

How many of these veterans who have been denied medical care and outpatient care are aged 65 years or older?

Dr. WINSHIP. I don't have that particular number. We, I believe, can supply that for you, Mr. Chairman. I suspect that it will be a number that is very close to the percentage that is in our care system, approximately 40 percent.

(Subsequently, the Department of Veterans Affairs submitted the following information:)

At the May 12, 1989, hearing, Dr. Gronvall testified, as follows: "During this current year, we have had an increased number of veterans seeking care in the VA during that five month period of about 161,000 (this number was subsequently corrected by the VA to 150,000). That is about a 10 percent increase above a year ago.

We have, because of the constraints on our system and personnel shortages and beds closed, treated about 20,000 fewer veterans in our hospitals during that time—that is on a base of 500,000—and we have provided about 65,000 fewer outpatient visits also during that five month period. That is on a base of about 8,500,000." (After the hearing, the VA found these figures were based on a planned vs. actual projection and, in fact, outpatient clinic visits during that five month period actually increased slightly.)

We do not collect the exact data requested. However, we do know the number of veterans that we treat, by age group. Applying the age group percentage to the 20,000 veterans not receiving hospital care, provides the data in the following table:

Age	Hospital Care
65–74	7,064
75–84	1,822
85+	461
Total	9,347

Using these figures, the percentage of over age 65 hospital care applicants not receiving hospital care is nearly 47 percent.

Mr. EVANS. There is also a phenomenon of veterans just below medicare age, many of whom do not have health insurance, have no other place to go, or if they do have health insurance, it has lapsed, who are too young for Medicare and marginally above, for example, in my State, the Illinois State Medicaid Program.

Do you have any statistics on these people who might not technically be elderly, but who will soon be in the elderly ages of life and who may be putting off needed health care? I would like to look at that as a part of the equation too. Could you give me information on those who are from 55 to 65?

Dr. WINSHIP. We can certainly analyze that for you. I think that would be very appropriate.

(Subsequently, the Department of Veterans Affairs submitted the following information:)

The VA does not maintain the exact data requested. We do, however, know the number of veterans that we treat by age group. Applying that age group percentage to the 20,000 veterans not provided hospital care, calculates the figure at 7,081 for the 55 to 64 year age group. It is conceivable that this group of veterans could be more vulnerable to needing care after age 65, as a result of not receiving all the needed care during the previous ten years of their lives.

Mr. EVANS. Do you know the number of veterans aged 65 or older who have been denied VA nursing home care and VA contract nursing home care during the same period?

Dr. WINSHIP. I do not have the numbers in that particular form.

(Subsequently, the Department of Veterans Affairs submitted the following information:)

We do not maintain the requested information regarding the number of veterans aged 65 or older who applied, but were not provided, VA nursing home care and VA contract nursing home care during the first six months of this fiscal year. The actual admission data for the first quarters of each of Fiscal Years 1988 and 1989 is provided below. We estimate that slightly less than one-half of the "Difference" numbers are comprised on veterans aged 65 or older.

Category	FY 1988	FY 1989	Difference
Contract Nursing Home	7,460	5,636	−1,824
VA Nursing Home Care	3,810	3,696	−113

Mr. EVANS. How many of the 13,000-plus VA hospital beds found to be closed last year have been converted to nursing home care beds?

Dr. WINSHIP. This year we will be converting—I have those numbers here. Just a moment.

[Pause.]

Dr. WINSHIP. This year we will be converting 325 beds to nursing home care beds. These are from other kinds of care, in the main beds that have been closed or out of use for some other purpose. That is in fiscal 1989. In fiscal 1990, we are expecting about 360. This is approximately three nursing homes at 120-beds per nursing home, if you want to look at it in that way.

Mr. EVANS. But in the next two years, roughly 700 or so beds out of the 13,000 that we have vacant?

Dr. WINSHIP. Yes.

Mr. EVANS. Is it because of budgetary reasons that you are not able to convert more?

Dr. WINSHIP. Yes. That is one of the major reasons. It is because of budgetary reasons, for staffing, for conversion costs, and for construction. In some instances, of course, where there is availability of those beds for conversion, that is not the place where we really need the nursing home beds the most. Where we do need nursing

homes, frequently those beds are not available for conversion and therefore other options would be required.

Mr. EVANS. Dr. Adelman, one of the responsibilities of the Geriatrics and Gerontology Advisory Committee is to assess the capability of the Department to provide high quality geriatric extended and other health care services to eligible older veterans, taking into consideration the likely demand for such services for such veterans.

Is the Department fully capable of providing high quality geriatric extended and other health care services to those veterans who need these services in the years 1990, 2000, 2010 and 2020, for example?

Dr. ADELMAN. I think the realistic answer is no, but I want to qualify it. The VA has historically played an extremely important role in the development of knowledge and model systems of care related to elderly people. What they have done in these model programs in the GRECCs have impacted enormously on hospital systems outside of the Department of Veterans Affairs. So there is no question that the knowledge about what to do exists, and, in fact, more frequently than not originated within the Department.

Unfortunately, there are so few of these model programs and the lessons taught by the model programs have not been integrated into the Department's mainstream. Yes, they are caring for elderly people, but no, they are not taking advantage of the new knowledge being developed.

Mr. EVANS. You are referring to the GRECCs being the models?

Dr. ADELMAN. Yes. I think if you looked at an individual GRECC it would be fair to say that the best available care to elderly people is being provided to the veterans that go through those GRECCs. But that is a trivial percentage of the entire health-care system with which you are concerned.

Mr. EVANS. Are you advocating that each VA medical center have a GRECC established over a period of time?

Dr. ADELMAN. Well, I think it would be unrealistic to speak in terms of very many more GRECCs. The purpose of the GRECC is to show that a model program can deliver and develop the right kinds of care, the right kinds of information. What is needed is a national plan to apply what is being developed in the GRECC throughout the health-care system.

I won't argue with you as to how many more GRECCs there might be, although, as you undoubtedly are aware, more than the funded number have been authorized and matters could be helped somewhat if some of those additional GRECCs were indeed selected and funded.

Mr. EVANS. Doctor, you noted the lack of an entitlement for long-term care. My question for the panel is should there be an entitlement for nursing home care or extended care, and what should the entitlement encompass? Could you each give me your response to that, starting with Dr. Adelman and moving to the right?

Dr. ADELMAN. Remember I speak as a nonphysician as an academic, and with that reservation I think it is clear to those of us who look at this system from the inside that acute medical care for the elderly is overemphasized by the Department and more chronic long-term care, although demonstrated well in model ways, is un-

deremphasized for the elderly in the Department, and something must be done to change that distribution of services.

One of the most important things needed as a foundation for this change is the training of all those service providers in the modern tenets of geriatric medicine and the delivery of other kinds of geriatric services. Most of the service providers in the Department are not remotely trained in current issues of geriatrics.

Mr. EVANS. Would that be part of the national plan that you were talking about?

Dr. ADELMAN. Absolutely. The kinds of programs exist, the regional training sites exist, but without the message of the congressional mandate history dictates that the bureaucracy will not move. That is how we view it from the outside.

Mr. EVANS. Who should develop the national plan? Should the Congress mandate it? And then who should develope it?

Dr. ADELMAN. Well, in my opinion, Congress should mandate it. I think you have the expertise in the Office of Geriatrics and Extended Care. I would suggest that the Advisory Commission which I chair can continue to play some kind of advisory role in working with the Office of Geriatrics and Extended Care, with the Office of Clinical Affairs and others so that these programs can be developed.

Mr. EVANS. Any other opinions on the topic of extended care entitlement?

Dr. WINSHIP. Your specific question had to do with entitlement and what should we do with entitlement. I was just looking at a summary of all the care eligibility by entitlement, whether it is mandated by law or discretionary, and, of course, all of the VA nursing home care at the present time, by law, is discretionary. This year I think really for the first time has presented us with a major difficulty, and that is, that with the budget situation we have been forced to carry out some workload reductions and, because of the budget limitations, have been forced to look first to those discretionary kinds of patients, in which all nursing homes are included.

I believe that it would be appropriate for the Congress to make mandatory nursing home care for those patients for whom health care is mandatory. But I think it would be inappropriate for Congress to do that by legislation without appropriating resources to take care of that because I think that really is where the problem is at the moment, or a major portion of the problem.

Mr. EVANS. I want to have Mr. Adelman's comments on that point.

Dr. ADELMAN. I can't resist the opportunity to say, and with all due respect to my medical colleagues, part of the problem is the incredible dominance of the medical care system within the Department of Veterans Affairs. I am not trying to demean it in any way. God knows, it is necessary. God knows, it does a good job. But the problem is that elderly people need more than health care and it shouldn't always be determined by those who provide health care. There is other kinds of expertise besides the physician, with all due respect.

Mr. EVANS. Would you like to make a comment, Tom?

Dr. YOSHIKAWA. Mr. Chairman, I also agree that, because of my obvious bias and responsibility, that long-term care should be an entitlement. I think in the future as we face continued budgetary problems that when the time comes to take the axe it is going to be long-term care. I think it is very difficult for our office and people in our programs to continue on, in the face of the demographic imperative, to go out to the field and say it is important to continue care of the elderly when, in the future, we can see that this is where the budgetary cuts will be taken. So I feel it should be an entitlement within, obviously, the constraints that Dr. Winship has mentioned, that is if patients were obviously eligible for care.

Mr. EVANS. How do we focus such an entitlement? It seems to me Dr. Winship had talked about extending an entitlement to those who would be able to get, as I understand, VA medical care or inpatient medical care. How would you try to focus on entitlement for extended care? Would you try to do it in the same way? We are not going to be able to extend it to every veteran needing it from what I can gather.

Dr. YOSHIKAWA. Right. Currently, as you know, we are mandated by law to provide care for the Category A patients. I would think that at the first level, inpatient acute medicine, surgery, ambulatory care and extended care should be entitlements for that group of patients. So, if they are going to be entitled to acute care and ambulatory care, certainly they should be entitled to long-term care also. It is a part of the continuum of care.

Mr. EVANS. Let me ask the whole panel about the number of GRECCs. The number of GRECCs has been constant at 10 since 1984, although Congress has authorized 25, and in 1984 the VA itself proposed 30 by 1990. Why are there only 10 fully established GRECCs?

Dr. WINSHIP. I can certainly comment on that. Over the last year and a half, we have taken some steps to begin to gradually increase the number of GRECCs. One of the major problems has been budgetary constraints. We have within the last year approved two more new GRECCs, at Ann Arbor and at San Antonio. Unfortunately, about the same time that those approvals came through and we were developing plans for funding those, it was a very difficult situation in terms of our budget.

Mr. EVANS. Doctor, the Department itself has not requested additional funding in its budget, has it?

Dr. WINSHIP. Formally, no. Officially, no.

Mr. EVANS. Formally or informally. I don't think it has been in the formal budget submission.

Dr. WINSHIP. It has not been in the President's budget submission; that is correct.

Mr. EVANS. Would that indicate reluctance to go ahead and develop the number of GRECCs that have been authorized? Mr. Adelman talked about problems within the VA generally in terms of dealing with some of these issues, perhaps bureaucracy and hesitancy. If you are not asking for the money, does that indicate a kind of a bureaucratic hesitancy at the highest levels to not go ahead with the program and to not help establish more of these GRECCs?

Dr. WINSHIP. Yes. I believe that our problem has been, perhaps, a failure to be absolutely convincing and compelling as to the priority of the GRECC program in the face of other priorities and budget constraints.

Mr. EVANS. You are not going to be able to tell me if the additional funding for GRECCs was included in the budget submitted to OMB before its submission to Congress?

Dr. WINSHIP. Yes, I believe it was.

Mr. EVANS. I would like to recognize at this time Congressman Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Let me just follow-up, Dr. Winship. If you had the money and the plans to go ahead with establishing more GRECCs, what criteria would you use as far as the location of those?

Dr. WINSHIP. We have those criteria very well spelled out. I would like to ask Dr. Yoshikawa to comment on that, if you would, please.

Dr. YOSHIKAWA. Yes. Currently, we have now implemented a program where the individual medical centers, given the usual criteria for having the medical school affiliation and other essentials, propose a plan through the MEDIPP—the Medical District Initiated Program Planning process, and that is the first level that these proposals will come through. Once these are then reviewed and appear to be appropriate at the first level, these proposals will then come to our office and then be reviewed by a panel of experts outside the VA, and also within the VA, in terms of the strength of the proposal, the regional needs, and the quality of the proposal. This process is now in place.

Mr. STUMP. Regional needs, would you mean that where those aging veterans may be?

Dr. YOSHIKAWA. Right.

Mr. STUMP. Would you work with the Bureau of Census to find out, to determine where the largest population live?

Dr. YOSHIKAWA. We have that information. We know where there is the largest population of veterans. And there are some areas that even though they may not have a concentration of older veterans, certainly they also need a GRECC too in terms of the local regional needs.

Mr. STUMP. Mr. Adelman, did you have a comment?

Dr. ADELMAN. Congressman, there is a misconception, not only within the Department but certainly outside the Department, that the elderly represent one of many interest groups. The demographics tell us the entire veterans population is growing older. Blind veterans are also suffering other problems of the frailty associated with old age. Veterans who were not blind are suffering failures in eyesight. The same can be said about each of the special interest groups. We are not suggesting—we, the Advisory Committee—are not suggesting in any way that the elderly be given more benefits at the cost of others. But what the Department does best it should continue to do, but with the understanding that people are growing older and the tenets of geriatric health care are such that the system must change.

Mr. STUMP. Thank you. Thank you, Mr. Chairman.

Mr. EVANS. Mr. Adelman, let me follow up right on that point. I had asked earlier about the problem of people who aren't technically elderly now. I have met with many veterans who don't qualify yet for Medicare, they are too young, or are over the State Medicaid limitations, they have no health insurance, and they are being discharged now from places like Iowa City, Iowa, in a stable condition. If they don't get the medication that they need now or if they don't get other needed treatment, are they going to come into our Medicare system or perhaps our VA system in worse condition, and will it require more resources to treat an aggravated condition?

Dr. ADELMAN. I believe so. But I think you should hear from a geriatrician in answering that question, such as Tom Yoshikawa. Let me say before I defer to him that one of the major problems is that the Department, and indeed the rest of the Federal bureaucracy, tends to think in terms of chronological age as a major determination of entitlement for service delivery. The problem is that we should be worrying about functional deficit. If someone can't do something well, then there ought to be some kind of treatment. If it is a medical problem, there ought to be medical treatment. If it is a social problem, there ought to be social treatment. Whether or not the Department of Veterans Affairs does something different than the Social Security system or Medicare is for people such as you to decide, but it ought to be done rationally.

Tom, maybe you can address the geriatrics.

Dr. YOSHIKAWA. Thank you. I think in the hypothetical sense, yes for those individuals who fall into that age category. The age category of what is considered elderly depends on to which expert you talk to. It sort of moves up and down from age 65.

But certainly in the veteran population, the elderly is a large group; for instance—I just have some numbers here. You know that 24 percent of today's veterans are age 65, but if you look a little further down the age category, for example, age 55 and older, the veteran population is currently 49 percent. So we are looking at a large group. And if we anticipate that this group eventually will fall into that age category that will be experiencing debility, frailty, and other chronic conditions, it is possible that these individuals who did not get early diagnostic and preventive type of care could enter the system elsewhere; for example, Medicare, in a worse state.

So, in essence, it taxes the whole health-care system. Dollars come from the same place, in essence. So I think we, the VA, can contribute in preventing that scenario by, providing care for our veterans and then not using the other health-care system.

Mr. EVANS. Tom, I hope you are going to be able to stay for some of the other testimony. I know the Illinois AMVETS will be testifying about a program they plan to establish at the University of Illinois with Dr. Alvar Svanborg, based on the Swedish experience with the elderly.

Have you had a chance to review what they are proposing and what has happened in Sweden?

Dr. YOSHIKAWA. Yes, very briefly.

Mr. EVANS. Do you have any opinions about the purpose at this point?

Dr. YOSHIKAWA. To be honest, I got the report last night, so we have not had a chance to evaluate it in depth. Preliminarily, I think that at this moment we have a few concerns in terms of the cost and the Veterans Affairs contribution toward patients for that program. But beyond that I think it is hard for me to comment since we haven't had a chance to evaluate it.

Mr. EVANS. Could you review that report and, perhaps, give us a small summary of your opinions about it after you have had a chance to digest it?

Dr. YOSHIKAWA. Yes, I would.

Mr. EVANS. Your submission will also be included in the record of this hearing.

(Subsequently, the Department of Veterans Affairs furnished the following comments:)

The concept of providing a short term, intensive program of reactivation provided by a highly skilled staff for functionally disabled veterans following a period of hospitalization appears to be a sound one. At least two practical considerations need to be addresses before the Agency makes a commitment to the project. First, it is not clear to what degree the VA budget can support this project at a time when we are experiencing an overall shortage of funds. Second, it is not clear whether the numbers of potential VA patients are sufficient to provide 70 percent of the referrals to the program.

This project is under review by the Agency at this time and further discussions will be undertaken with AMVETS to determine the extent of VA commitment it is seeking or will require. Since the VA will not likely be able to pay for empty beds, a specific needs assessment may have to be conducted to determine the likely number of actual referrals meeting AMVETS criteria, consistent with the goals of the community nursing home program. AMVETS will need to consider contingency plans for the viability of the project should adequate numbers of referrals fail to materialize. In addition, the time length of the VA commitment needs to be determined.

Mr. EVANS. Mr. Adelman, when I asked your about GRECCs I should have asked you would recommend that a formal geriatrics component, not necessarily a GRECC but, perhaps a geriatric section, an Assistant Chief of Staff for Geriatrics or a GRECC be established at each of the medical centers? I used the term GRECC, but I meant something maybe less inclusive.

Dr. ADELMAN. Yes, I would agree with such a recommendation, recognizing that needs differ enormously from region to region and hospital to hospital. In some cases it might suffice to have an individual knowledgeable in geriatrics to give advice to the other services, and the other extreme would be a full-blown program in geriatrics and long-term care. But some kind of trained, knowledgeable geriatrician ought to have formal responsibility in every veterans hospital if they are going to implement appropriate changes for care to the elderly veteran.

Mr. STUMP. Mr. Chairman, I just have a couple of questions I will submit for the record.

Mr. EVANS. Did you have something else, Dr. Winship?

Dr. WINSHIP. I just want to clarify for the record the comments I made about the entitlement a moment ago. I made those comments in answer to the question about what could Congress do. I think that in all fairness I should say the VA at the present time has no formal official position about whether that entitlement should be added or not. I think that if that comes down we certainly would want to look at that and have that discussion with you.

Mr. EVANS. Thank you for clarifying that.

I thank the panel for their excellent testimony today. We will be submitting additional questions, both the minority and majority of the subcommittee, and those questions and your written responses will be made a part of the official hearing record of the proceedings.

Dr. WINSHIP. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Mr. EVANS. The members of the second witness panel will please come forward and be seated. They are: John Sommer, director, National Veterans Affairs and Rehabilitation Commission of the American Legion; Noel C. Woosley, national service director, AMVETS, who is accompanied by Dr. Alvar Svanborg, Professor of medicine, Chief, geriatric medicine section, clinical director of research, gerontology center, University of Illinois at Chicago; and Howard L. Stone, chief counsel to the Department of Illinois AMVETS.

I am also pleased to recognize—and I hope he will stand up for our applause—the former National Commander, a fellow former marine, Jim King, of Illinois.

Jim, if you would stand, we welcome you to the committee.

[Applause.]

Mr. EVANS. We will begin with Mr. Sommer. Again, as you know, you may summarize from your prepared statement, which will be fully included in the record, without objection. Thank you for coming.

STATEMENTS OF JOHN F. SOMMER, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; NOEL C. WOOSLEY, NATIONAL SERVICE DIRECTOR, AMVETS, ACCOMPANIED BY ALVAR SVANBORG, M.D., PH.D., PROFESSOR OF MEDICINE, CHIEF, GERIATRIC MEDICINE SECTION, CLINICAL DIRECTOR OF RESEARCH, GERONTOLOGY CENTER, UNIVERSITY OF ILLINOIS AT CHICAGO, AND HOWARD L. STONE, CHIEF COUNSEL TO THE DEPARTMENT OF ILLINOIS AMVETS

STATEMENT OF JOHN F. SOMMER, JR.

Mr. SOMMER. Thank you, Mr. Chairman. The American Legion is pleased to take this opportunity to present its views on a number of issues relating to the health care requirements of the Nation's aging veteran population.

VA programs for aging veterans are extremely important, and we commend the subcommittee for examining this subject, so as to ensure that VA not only is providing appropriate treatment and services for the aging veterans today, but is also planning to increase and expand these programs in the future as the needs escalate.

Unfortunately, we understand the percentage of VA physicians possessing board certification in gerontology is small in comparison to the demand. This is reportedly a problem in the private sector also. However, as medical school affiliates continue to modestly expand the residency training programs in the field of geriatrics, VA must prioritize resources to meet its needs in this area.

The further expansion of the GRECC program will promote the recognition of the role of geriatric medicine in today's society to a certain extent. However, as was mentioned earlier, out of 25 GRECCs that are currently authorized only 10 are funded.

One of the major problems that confronts VA, as well as the entire Nation, is the growing need for nursing home health care units designed to provide different levels of care. Because of some misguided information provided by the Grace Commission and others unfamiliar with the VA health care system, there has been an effort to discontinue the construction of VA nursing units on the grounds that they are too costly in comparison with the cost of construction of similar units in the private sector. This is, we feel, a good example of the fallacy of much of the rationale developed by those who are bent on privatization of the VA medical care system stemming mainly from a fundamental lack of understanding of the mission of this program.

It must be stated that the services for the aging veteran population along with other programs carried out in the medical care system are in danger of being reduced or deleted as a result of funding shortages. As you know, Mr. Chairman, the fact that the budget for the VA medical care program has been decremental over the past several years has now forced the closure of beds, curtailment of treatment programs, elimination of treatment of many nonservice-connected veterans, excessive waiting times for admission, and the closing of clinics. Contracts with community nursing homes are being reduced and in some instances totally eliminated. The recent survey of all medical center directors that was completed by the American Legion reflected that well over 70 percent of the VA facilities had either reduced or eliminated these contracts.

The Government must provide adequate and necessary funding to maintain the programs of the VA medical care system, provide adequate compensation levels to attract and retain the highest quality professional staff, and ensure funding for renovation and replacement of the aging and inadequate facilities.

Mr. Chairman, that completes our summary.

[The prepared statement of Mr. Sommer appears at p. 54.]

Mr. EVANS. Thank you.

We will hear from the AMVETS.

STATEMENT OF NOEL C. WOOSLEY

Mr. WOOSLEY. Mr. Chairman and members of the committee, thank you for this opportunity. AMVETS thanks you.

When we received your invitation, I thought it fitting that—we have a project, a pilot project going on in your home State, as you know, Mr. Chairman—that we bring somebody in and share with this committee the thoughts on new and innovative things we can do with the elderly as opposed to warehousing. So my job this morning is easy. I am going to introduce Howard Stone.

STATEMENT OF HOWARD L. STONE, CPA, J.D.

Mr. STONE. Thank you, Mr. Woosley. And, Mr. Chairman and members of the subcommittee, thank you for giving me the privilege and honor of appearing before you.

Before I start, I would like to tell you what my background is, because I truly believe I bring an unusual background to this subcommittee. I am a CPA. I spent 9 years with the Internal Revenue Service, 4 years with the Department of Justice, and 12 years in the practice of law in litigation and health care and in the areas that I was trained in. I have represented owners of nursing homes. I have represented government agencies. I have represented and appeared on behalf of the University of Illinois, and I am on the faculty of the University of Illinois, lecturing in the area of long-term care, and together with the AMVETS and the Veterans Administration we are currently working on a project to reactivate veterans. That is a project that will take veterans who are heading towards a nursing home and turn them home to their families and to their communities.

This is the first facility of its kind that I know of in the country and it will follow a Swedish model. The AMVETS have made this commitment because they believe that the commitment should be made to keep veterans healthy and at home as long as possible and to curtail their ultimate institutionalization.

We have worked for the last 4 years with the Veterans Administration, and I can tell you that without a doubt Dr. Winship, Dr. Kelly, Paul Stanford, from the Westside VA, and John Fears, from the Hines VA in Maywood, Illinois, have with their staffs—they have turned over—Heaven and earth in terms of an attempt to help the AMVETS plan and implement this project. Our final step will be getting a higher level of reimbursement from the VA to assure the success of the project so that the proper treatment can be given to the veterans and that the proper studies can be done to assure that this type of a program can be implemented.

I returned from Sweden a week ago. I went through their system, one that was in large part created by Dr. Svanborg, and I can tell you that it was really Disneyland over in Sweden.

With that I am prepared to answer all of your questions.

At this time I would like to introduce you to Dr. Svanborg.

[The prepared statement of Mr. Howard L. Stone appears on p. 63.]

STATEMENT OF ALVAR SVANBORG, M.D., PH.D.

Dr. SVANBORG. Thank you. Mr. Chairman and members of the subcommittee, I would like to just make some general statements. I am not going to talk about the Swedish system.

Over the last two decades we agree that knowledge about what human aging really means has improved considerably. However, diagnostic criteria still are not always adequate for a differentiation between manifestations of aging and symptoms of disease. We all know that overdiagnosis and underdiagnosis are unacceptably common as well as overtreatment and undertreatment. One of the reasons why this is the case is that we often need more time and longer observation periods in elderly patients for adequate diagnosis and evaluation of treatment.

We have also generally thought that aging is almost totally dependent on our genetic factors; either we have good parents or bad parents, from that point of view. We know today, however, that

lifestyle and environment as well as availability of adequate medical care plays a much greater role not only for state of health in general, but also for those processes we today identify as aging.

And we know, for example, that activity is important for the stimulation of cells and organs. We know that still at age 80 and over we can train muscle strength. We can train fiber compositions in the muscles so we can improve not only muscle strength but also the quality of muscle function. We know that we can influence also upon the rate of decline, for example, of the density of the skeleton and the stability of the skeleton to a much greater extent. And, I repeat, that is still the case—we have studied it longitudinally at least at ages 82-83—above age 80.

We also know that reactivation—if I may call it so, retraining your performance—is possible at ages above 80 after episodes of curable disease to a much greater extent than was usually considered previously. But, unfortunately, many elderly show a stepwise decline in performance because of the fact that their own reserve capacity is too low and they do not get the assistance they need to retrain. Many of them after acute, also as I said, curable disease will never regain the physical performance they had one week before namely, when they acquired this disease. Many of them end up in nursing homes without resources for reactivation, and they become, therefore, long-term care patients.

Of course, geriatric units within acute hospitals can help them to a certain extent. But many of them need longer periods of treatment and reactivation, and it is not possible today to give that in our hospital settings. We, therefore, need to use the nursing homes in another way, in a more active way than we have done before; and that is the plan.

I would also like to add, of course, that from the university point of view it is extremely important that we have the possibilities to teach and do research also in the nursing home section.

Thank you.

[The prepared statement of the Dr. Svanborg appears at p. 58.]

Mr. EVANS. Let me yield to my colleague from Arizona, if he has any questions.

Mr. STUMP. I don't have any questions. I would just like to thank them all for their statements and for appearing before us today.

Mr. EVANS. Would the gentleman from Florida like to be recognized for any questions? I know you just arrived.

Mr. STEARNS. Thank you, Mr. Chairman. I apologize for getting here late. I was at a Banking Committee mark-up. I am pleased to be here in this important committee, and thank you for your indulgence.

Mr. EVANS. Thank you.

I, of course, am very interested in the status of the Illinois AMVETS Teaching Nursing Home Project. Can you tell us when the project should become a reality?

Mr. STONE. We have submitted a plan to the Veterans Administration and it will be reviewed by them. They have participated with us in a very meaningful way in the planning of the project, but, obviously, it has to be a project that, if they can deem if they can fund it, then that is going—as I indicated in my testimony, Mr.

Chairman, it is going to require, because of what we are doing, a higher level of dollars.

However, one of the things I just learned over in Sweden which was very interesting and I think as a result of this direct impact of reactivation there was a study that started 10 years ago in Dr. Svanborg's district in Goteborg, and the nursing home beds at the time of the study were projected to go up 50 percent—2,000 beds were projected to go up to 3,000 beds—and the 80-plus population was projected to go up 36 percent. The 80-plus population did go up 36 percent, but the number of nursing home beds at the end of 10 years went down. What does that tell you? It tells you that individuals were kept out of long-term care, they were kept at home. And, if we start taking a look at the finances and doing a study, I submit to you that without massive interventions that probably the country or the government in Sweden ended up saving a great deal of money.

That is a matter that we want to study in the reactivation center: Can we save money by sending people home to their community?

Mr. EVANS. We would appreciate receiving written copies of the testimony which you have presented for includsion in the hearing record. The executive summary of the project refers to needless institutionalizations, inadequate and incorrect medical diagnoses. How prevalent are these in our VA hospitals, at least in your own experience?

Mr. STONE. Well, I am going to outside the VA hospitals and tell you that in long-term care there have been various studies that have been done in this country indicating that between 30 to 50 percent of the people in long-term care institutions shouldn't be there. The most recent studies that I read, which was about a year ago, was one done by the State of New York, their Department, I believe, of Public Aid or Public Health. So, in terms of diagnostics, if we use that as a criteria, there are studies that indicate that there is a large number of individuals who are institutionalized that don't belong there. Form a VA point of view, perhaps Dr. Svanborg can speak to that, but I don't know.

Dr. SVANBORG. I have experience from a longitudinal study of 70-year olds over in Sweden where we have followed people from age 70 to 80-85. There is no doubt that there is much, as I said, overdiagnosis and underdiagnosis in the elderly. We know also through intervention studies where we have seen to what greater extent, for example, we can help people after hip fracture than was earlier thought possible. We know today that by systematic training within the nursing home sector, we have been able to prove that after 2 to 3 months of systematic reactivation patients were in a better muscular and cardiovascular adaptation condition than they were when they fell.

So we can do much more for these people to reactivate them, and that is the plan with this nursing home.

Mr. EVANS. We heard the testimony of Congressman Florio and the projected number of needed new hospital beds and nursing home beds. We heard that the VA doesn't have the money to convert some of the existing hospital beds to nursing home care beds. According to your testimony there is a potential for saving some of

those costs if we adopt a program such as you are proposing and possibly avoid de-institutionalizing so many people. The teaching nursing home has a $170 per diem component. Can you tell us what some of the components of this cost are? Why it would be justified? What we would receive for that $170?

Mr. STONE. Well, first it would be a different type of staffing than is available in probably any nursing home in the country. When we take a look at the Swedish model and different types of equipment, and that is one of the reasons I went over to Sweden, is we will staff the departments with professionals. The secret to the success in Sweden, as I have seen it, and in talking to the professionals is that when physical therapy is done in the physical therapy department it is done by physical therapists with the assistance of aides, but the physical therapist does not leave the physical therapy department. They supervise the cases.

Am I right? Am I overstating it?

Dr. SVANBORG. Yes, I think so; but we have heard earlier that geriatric care is an interdisciplinary effort. It is a combination of work with, of course, medicine as a dominating discipline, but with many other allied health professionals, e.g., social workers, et cetera. And this is an interdisciplinary effort that really could be performed in the nursing home setting when we have the resources available.

Mr. STONE. It will be staffed by physical therapists, occupational therapists, social service workers, more social service workers than you would normally find in a conventional nursing home because a part of what we have to do is plan for an individual coming in and also plan for the discharge and make sure that there are services available to that individual when they go to their community or home setting. We will have at least one full-time physician on the staff, and our nursing care and aide care, the staffing of those will be much higher than they would be in a conventional nursing home because of the need for intervention.

Mr. EVANS. As a result of the additional staffing, will the term of the stay be shorter?

Mr. STONE. We are anticipating a stay, we are hopeful that our stays run no longer than 90 days. In many instances, for dementia-type patients, much shorter.

Mr. EVANS. As a result of the program, are people better able to care for themselves and have some restoration of their bodily functions?

Mr. STONE. We would hope for that. We have also talked to the Illinois Department on Aging in terms of establishing for these types of individuals coming out for this study, establishing home care provisions so that the individuals coming out of these facilities will then be followed at home and would get the needed assistance that would keep them at home.

We would also hope to prevent subsequent rehospitalizations. It is not uncommon to see someone go into a nursing home and then within a short period of time find themselves back into a hospital setting.

Mr. EVANS. We think this is a very promising program, and want to thank the University of Illinois and AMVETS for starting this program. We will be looking with great interest, not only the sub-

committee but the full committee, at the progress and we will want to continue to be updated by all of you about the progress of the program.

Would the AMVETS and the Legion have any reaction to Dr. Winship's statement that the Department aims to provide nursing home care to only 16 percent of the 290,000 veterans who are expected to need it in the year 2000? Is that going to be a sufficient number for us to be able to say we are providing enough care for our veterans?

Mr. SOMMER. Speaking for the American Legion, Mr. Chairman, we would certainly have to take a look at those figures. However, the problem now, as has been mentioned earlier here today, is the fact that many veterans are being turned away, number one, and there is no real entitlement to provide nursing home care to veterans; therefore, if there is no change in the situation with respect to the funding of the Department, then there is going to continue to be problems.

As we mentioned, the survey that we recently completed showed that 71 percent of the medical center directors—which we got a 100-percent response rate in our survey, 71 percent advised us that they had either cut back or eliminated contract nursing home care in the community. In addition to that, you mentioned earlier the number of beds that had been shut down that were found in the survey that the committee staff had done. We have found that, coming forward since that survey, there have been an additional almost 2,700 beds closed in the VA for a number of reasons, mostly staffing and funding shortages; and of those, 225, I believe it was, were nursing home care beds.

So there is going to have to be some improvements made in the system if the VA is going to continue to be able to provide nursing home care to a sufficient number of veterans.

Mr. WOOSLEY. Mr. Chairman, thank you. Yes, the commitment from the Administration's standpoint to the aging is, apparently, to ignore it and maybe it will go away. And in the budget, they are going to decrease the census in the nursing homes as well as the domiciliaries, and we know that the people in the domiciliaries are the indigent, many times physically or mentally disabled. I don't know where these people are going to go. Surely we can't build enough nursing homes or enough beds. Hopefully, if the VA will cooperate with my colleagues here with me today, we can reactivate these people.

I should note the first thing the doctor told me. I said, "Oh, you are going to rehabilitate somebody," and he said, "No, young man. You rehabilitate athletes, you reactivate senior citizens."

Mr. EVANS. Do either of your organizations feel that there should be an entitlement for nursing home care, and how would we structure that entitlement if we were to establish it?

Mr. WOOSLEY. Well, I think what Dr. Winship alluded to would be those who are eligible now, mandated eligibility, be included in long-term nursing home care. If that is the way we go, we are going to affect a small number of those who probably will need extended care as elderly. And yet there is not dollars enough, I am sure, to take care of all of them, but that would be at least a step in the right direction to say, "If you are a service-connected dis-

abled veteran and you are eligible for treatment in this, then you should at least be eligible for continued long-term care if needed."

Mr. SOMMER. The American Legion would certainly support the extension of entitlement as currently exists for nursing home care at least, and possibly even to more individuals.

Mr. EVANS. Any other questions from my colleagues?

[No response.]

Mr. EVANS. If not, thank you very much for your important testimony before the committee today.

Mr. EVANS. Members of the final panel are Dennis Cullinan, Assistant Director, National Legislative Service, Veterans of Foreign Wars; Cmmdr. John F. Wanamaker, Deputy Director of Legislative Affairs, the Retired Officers Association; David W. Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; and Gordon Mansfield, Associate Executive Director of Government Relations, Paralyzed Veterans of America.

If you would all come forward, we would like to hear from you. And, again, starting with Dennis, we will incorporate your statements into the record, and if you can summarize we would appreciate it.

STATEMENTS OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; CMMDR. JOHN F. WANAMAKER, USN (RET.), DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, THE RETIRED OFFICERS ASSOCIATION; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND GORDON MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. I will speak briefly.

To begin, I would like to thank you behalf of our entire membership for inviting us here today to present our perspective on caring for this Nation's aging veterans.

The DVA health-care system is now being called upon to properly answer its greatest challenge, which is caring for the very rapidly aging veteran population. Although the entire American population is advancing in years, on the average the pace is much more rapid with veterans.

In view of the health problems associated with advancing years, the DVA's medical program now and in the future must be prepared for increased, diversified and more costly demand for services. The DVA health care budget is strained to the absolute limit, and it is now evident that the DVA is facing its most severe financial crisis in many years.

The very heart of the problem, not enough money. Even though Federal funding for veterans health care has nearly doubled since 1980, after inflation is taken into account there is practically no gain whatsoever. During this period the Department of Veterans Affairs' health-care system has been treating more patients than ever before.

The reality is that the rationing of health care is with us now. DVA medical centers are closing. We are not opening GEU and hospital-based home care programs due to budgetary constraints. Pharmacy cutbacks are evident in the limitations placed on the DVA formulary, a reduction in the provision of over-the-counter drugs and so forth.

The DVA is faltering in its preventive medicine outreach screening programs. GEUs need to be collocated in tertiary or active care facilities where the appropriate diagnostic equipment, laboratories and medical specialties are immediately at hand. Increased training and sensitivity-raising instruction needs to be made available to spouses, family members and volunteers tending to the needs of the frail elderly.

A major concern, simply stated, is helping the generally well and frail elderly to remain in the home and community setting. We are convinced that the noninstitutional care programs are the most cost effective in the long run, and we most certainly support the reactivation of aging veteran populations—aging veterans.

There is need for increased visibility of the GRECCs to include more and broader dissemination of reports of milestones achieved in the area of geriatric research, education and clinical care. The number of GRECCs should be increased from 10 to 15. GRECCs are centers of excellence designed for the advancement and integration of geriatric and gerontological research, education and clinical achievements into the total DVA health-care system. An expanded GRECC program will allow the DVA to maintain its clinical and educational leadership role in dealing with the problems of the aging. It will foster the development of new approaches to care to meet in turn goals of improvement in care and cost containment.

In summation, Mr. Chairman, much time has been wasted since the aging veteran report was released in 1984. It is essential that the DVA not lose its leading edge as the state-of-the-art, long-term care, geriatric care model for the Nation. If the DVA health care delivery system does not move more rapidly in the next five years, the diminishing edge will have been lost and both veterans and the entire Nation will be very much the worse for it.

Thank you, Mr. Chairman.

[The prepared statement of the Mr. Cullinan appears at p. 64.]

Mr. EVANS. Thank you. Commander?

STATEMENT OF CMDR. JOHN F. WANAMAKER, USN (RET.)

Commander WANAMAKER. Thank you, Mr. Chairman.

Before I start my statement I would like to make a few observations on the testimony that has been given here earlier this morning. In the first place, we talk about 27 million eligible veterans for health care. With the passage of Public Law 99-272 the Veterans Health Care Amendments Act of 1986, under the current rules B and C category veterans are, for all general purposes, disenfranchised from the health-care system. When we get down to it 85 percent of the so-called 27 million veterans are no longer able to go to the VA system and be assured you are going to get the care.

Now, to back that up, I would just like to read a little of a New Year's message that went out from the Medical Center, from the

Veterans Administration, at Ann Arbor, Michigan. This was a letter dated 27 December 1988. I will read the second paragraph:

"Effective January 3, 1989, Category B and C veterans will no longer be eligible to receive medical care or service from the Ann Arbor Veterans Administration Medical Center or the VA Outpatient Clinic in Toledo. Unless you are notified that you have been discharged from the Outpatient Clinic, you may keep those appointments already scheduled that fall after January 3. You will not, however, be able to schedule any additional appointments."

That, to me, is a disenfranchisement of B and C category veterans.

With that observations, I would like to proceed with my statement, if I may.

The members of The Retired Officers Association would wish to thank the chairman and members for holding these timely hearings. There currently exists a situation whereby many older veterans are being subjected to out-of-pocket costs for their health care exceeding those that are required by nonveterans in the same age bracket. I specifically refer to those veterans in Category C, over age 65, and eligible for Medicare.

Mr. Chairman, part of the dilemma faced by the aging veteran is the inconsistency in the Federal statutes—Public 99-272, the Veterans Health Care Amendments Act of 1986, and Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988. These conflicting laws would be further exasperated should the Administration's legislative proposals to establish a "user fee" tax on certain veterans who seek medical care at VA facilities. These user taxes would require many aged veterans to pay $5 to $10 for each outpatient visit, $3 to $5 per outpatient prescriptions, and a $9 per diem tax for inpatient treatments.

Public Law 99-272, which became effective on July 1, 1986, was a dramatic reduction in the health care provided to older, over age 65, veterans who before that date were provided care in VA facilities regardless of income. After that date, veterans in Category C—incomes of $20,000 if single, $25,000 if married; and, those have been indexed by about $2,000 each—are now required to pay a deductible for their health care provided by the Veterans Administration. By establishing a Category C status, it then became a device for the VA facilities to refuse care when reduced staffing and availability of facilities were attributed to budget restraints. In fact, many facilities wrote their patients of longstanding that their facilities would no longer be available to Category C veterans.

With continued budget uncertainties for VA health care and no assurances that there will be any continuity to their care, many older veterans are now changing their providers to the private sector. In most cases they are eligible for the Medicare program. The scary situation occasionally surfaces whereby an aged veteran accustomed to receiving care in a VA facility, and in some instances military treatment facilities, now find that care no longer available, and because of that availability for so many years they did not enroll in Medicare Part B. Now they suffer a significant financial penalty for late enrollment.

A veteran in Category C is also required by Public Law 99-272 to pay a cost share for Medicare deductible for the first 90 days stay in a VA hospital plus a one-half deductible for each additional 90-day stay. Public Law 100-360 establishes a catastrophic cost cap, beginning January 1 of this year, for health care provided Medicare beneficiaries. That law limits the deductible to a single deductible for each 365-day period. A veteran in Category C who may be admitted to a VA hospital, paying the required VA deductible, could be turned away on future visits—and this is becoming more and more frequent—and would then be required to rely on Medicare where he would have to start all over again and pay another deductible. This type of situation causes the aged veteran to be subjected to higher charges than other civilian citizens in his own age bracket who are not veterans.

In fact, he could be trapped into higher total medical costs by seeking care at a VA facility. The current Administration's proposal to establish a user tax would add to this dilemma.

Our recommendations to correct this problem would be to eliminate the means test for Category C patients over age 65, or require Medicare to be subject to reimbursement to the VA for care provided Medicare-eligible beneficiaries, or exchange the deductible credits between the VA and Medicare for the costs to beneficiaries of the limits established under Public Law 100-360.

I would hope, Mr. Chairman, that the remainder of my statement be included in the record.

Mr. EVANS. It certainly will. We appreciate your testimony.

[The prepared statement of the Commander Wanamaker appears at p. 67.]

Mr. EVANS. Mr. Gorman?

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. Good morning. It is a pleasure to be here before you today and be able to offer our views on this very important issue, and also to offer our congratulations to you, Mr. Chairman, and welcome you as the chairman of this very important committee. We look forward to working with you over the course of this Congress.

Mr. Chairman, it seems that today the VA is faced with many and varying degrees of challenges in the area of providing health care services to entitled veterans. None, however, may be as great and as immediate as is presented by aging veterans.

The simple issue, in our view, is the VA's capacity to treat the large influx of veterans whose need for both acute and long-term care will peak as this century nears its end. By the year 1990, one out of every four veterans will be 65 years of age or older, and by the year 2000, one out of three will be in that age group. Although many of these veterans will require acute care, many more will need skilled nursing care, especially as life expectancy increases. It has been estimated by the VA that some 5,000 VA hospital beds are now occupied by veterans who belong more appropriately in a nursing home bed. However, the VA itself does not have sufficient nursing home care beds and, for various reasons, are unable to place those veterans in community beds or other appropriate set-

tings. The fact that there is nowhere to place these 5,000 veteran patients underscores the dilemma the VA will be confronted with in the near future.

Mr. Chairman, the VA's Five-Year Development Plan, for 1989 through 1993, contains no new nursing home bed construction projects. Rather, that document simply stipulates the implementation of a long-term care policy that would tend to shift the provision of additional nursing home care beds away from new VA-owned nursing home beds toward community and State alternatives, as well as the conversion of existing VA hospital beds to nursing home care beds.

In addition to the ongoing efforts of the 10 GRECCs which we have heard testimony about today, the VA is able to provide, in our view, for veterans' long-term care needs via a variety of other methods such as VA domiciliaries, hospital-based home care, adult day health care, geriatric evaluation units, respite and hospice care, and the community residential program.

In order to deal with the ever-increasing needs, and in consideration of budget constraints, we feel it is very wise to concentrate efforts toward a rapid and substantial expansion of these types of noninstitutional health care programs.

Mr. Chairman, in recognition of the needs of older veterans, the DAV Department of California and the Sepulveda, California, VA Medical Center have entered into a joint pilot program called the Home Assessment Program for Successful Aging. The major goal of this program is prevention and early detection of diseases or disabilities in older veterans, as well as the elimination of health hazards in the home, in order to keep the veteran out of the hospital and in the home setting. I have attached some information regarding this program to my statement, Mr. Chairman.

[See p. 76.]

Mr. GORMAN.In conclusion, we would offer the following recommendations which we view as necessary simply to maintain the va's ability to continue to provide needed services to aging veterans:

One, a dedicated and meaningful policy to convert, where possible, unused or underutilized acute care beds to long-term care beds. Also, expansion of these noninstitutional health care programs that we have previously mentioned. Immediate expansion, to 15, the number of GRECCs, with a goal of having 25 GRECCs operational by fiscal year 1995. The establishment of Geriatric Evaluation Units at each VA medical center. An increase in the nursing home average daily census, rather than the proposed reduction of nearly 8,000 veterans treated in fiscal year 1990 as proposed by the Administration. Expansion, by new construction, of VA nursing home beds. Development of innovative ways to care for aging veterans, similar to the DAV and the AMVETS programs that have been mentioned today. And, finally, placing the appropriate emphasis on long-term care within the VA system.

Mr. Chairman, that concludes our summary, and I would be happy to respond to any questions you may have. Thank you.

Mr. EVANS. Thank you, Mr. Gorman.

[The prepared statement of the Mr. Gorman appears at p. 72.]

Mr. EVANS. Mr. Mansfield?

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STATEMENT OF GORDON H. MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman. Thank you for the opportunity to testify. One of the advantages of going last is that you have heard all of the numbers and a lot of the facts, so I think I will summarize my testimony and ask that the complete testimony be included in the record.

We know about the numbers of aging veterans and we know about the requirements for care. We know about the budget problems. We know we have problems right now with people being denied care, especially nonservice-connected veterans.

It appears that the VA Central Office health care leadership is not properly addressing this problem. As referred to earlier, the conversion of nursing home beds, planned for 325 or 360 is not sufficient to meet needs. And I would like to interject here, Mr. Chairman, if I could ask a favor, if you would ask the VA where those beds are going? Because I think if I remember the figure from last here it was eight and we should see what present plans really are.

The GRECCs centers of excellence and specialization. We have heard they are not transferring the knowledge to the health-care system in general. I thought that was one of the main reasons they were created.

In acute care, the medical treatment modality overemphasized, the long-term care underemphasized, or the medical care versus the full spectrum of care problem has been identified by a previous witness.

Especially in the area of GRECCs, I would like to make a request on behalf of the Paralyzed Veterans of America. We have attached to our testimony two letters which deal with our request and a supposed affirmative answer from the VA to establish a GRECC dealing with spinal cord injury. The reason I would emphasize this request is we are dealing for the first time in history with a unique population of spinal cord injured. This aging generation is the first one that has had the luxury of living long enough to get gray, and we know that there are special medical problems with spinal cord injury in acute care and I think we can anticipate that there are going to be special problems in aging care of SCI veterans also. We already know that there are, and I think it would be appropriate for a GRECC to study this type of care. And I would suggest again that the individuals I am talking about are spinal cord injured because of service to the United States.

Perhaps, sir, you could ask them in your written questions what the answer to establishing a GRECC to study SCI is.

Mr. EVANS. We would be glad to submit a question like that.

Mr. MANSFIELD. We also know that the construction and conversion program is less than needed. And, in answer to your question about Medicare, sir, 2 years ago PVA did a study called "Actions and Interactions" which was reported to the full committee, and in that, specifically, for example, in the Chicago area, we established that with a cut in VA health care services a lot of the people that are using VA health care are not eligible for other care or Medicare. And the answer from the Cook County Hospital Director, who would be the provider of last resort, when asked can you provide

care to these veterans was not just no, it was hell no, impossible. They can't do it.

Mr. Chairman, in conclusion, I think the VA is operating under what I would call a "Ponce de Leon theory". They seem to be waiting for somebody to come along and discover the fountain of youth. They are not planning for the already idenfied needs of aging veterans. I think hearings such as this can, perhaps, move them along the way to providing very much needed services, and the follow-up is needed. And I would like to close with this: We know from previous hearings on the VA health care that the VA people in the field, professionals to this at the medical centers, are dealing with a disastrous situation. I would suggest to you that what we are seeing here is that we are approaching an even worse situation, especially in dealing with the health care needs of the aging veterans. Thank you.

[The prepared statement of the Mr. Mansfield appears at p. 91.]

Mr. EVANS. Mr. Mansfield, thank you. We will certainly include some of those concerns in our questions.

I would like to start with you. I know the PVA has taken a position that long-term health care should be approached in terms of the whole population. This is perhaps a way of establishing resources throughout the whole country which assists veterans as well as nonveterans, like the Simon-Pepper approach. I appreciate that position. While we all want to provide for veterans here, by supporting the establishment of a network of home health care services, the support personnel who can provide those services, that is a unique approach for a veterans organization. I want to thank you for taking it. I don't know if you would like to elaborate on that today or not.

Mr. MANSFIELD. Well, maybe a comment. Maybe I am anticipating, but I heard the question earlier about the 16 percent figure. I think my immediate reaction is "where did the VA come up with 16 percent". Did VA sit down and in the context of a national policy figure out that they ought to and could take care of 16 percent? I would suggest to you that in the context of long-term care VA ought to get involved with the rest of the medical population in this country, and that there is a need for a national policy and there is a need to put the VA in the situation where it is defined what they have to do and that they are given the appropriate resources to deal with it.

Mr. EVANS. Do any of the other organizations have a comment about the possibility of an entitlement for nursing home care, given the 16 percent figure?

Mr. CULLINAN. Mr. Chairman, the VFW is of the opinion that it makes sense that those who are currently entitled to acute care should also be entitled to nursing home care. We also recognize how very expensive nursing home care is, and we would say that perhaps the B's and C's would have to be dealt with on a case-by-case basis. We would also point out that as the models and modalities for providing noninstitutionalized care are perfected the VA and the entire medical system should be able to provide better care to the aging veteran population more economically. We see that in part as an answer to that particular predicament.

Mr. EVANS. Mr. Gorman?

Mr. GORMAN. Mr. Chairman, on the issue of entitlements, I think last year this committee took a step in establishing outpatient eligibility for certain categories of veterans, not all of Category A veterans but of a part of it. I think that is an important segment too, because I think the access to outpatient care is ultimately going to diminish the need for inpatient care, and I think that could be explored also.

The DAV has no reason to see anything that is wrong with extending entitlement to nursing home care on the same basis as entitlements are extended now. One other thing that would go a little further than that is, and I haven't heard too much talk about, is I think there are a lot of things that could be done to keep veterans independent, at home, out of hospitals, and away from medical care that may not necessarily be needed if they had a little bit of help in such things as nonmedical care. Custodial care, housemaking and housekeeping services, Meals-on-Wheels—that type of thing I think would go a long way toward the independence of veterans. Currently, I don't think really the health-care system has the ability to use health care dollars for that kind of function. Maybe that might be something that deserves taking a look at in the future to see if in some segment of the Department it can be done.

Mr. EVANS. I would agree. At the same time we have seen the VA cut some of the programs. I was in Kansas City where they had cut back, at least temporarily, the adult day care program. That program allowed some families to, during the working days of the week, drop off an elderly relative in the morning and then pick him up at the end of the day. There were activities for this person, which I think helps their quality of care. So I think we also have to look at that way of providing, perhaps, respite for some of the families that do need help, particularly when they are working and so forth, as one component of this as well.

Commander?

Commander WANAMAKER. There is no question that has to be looked at. I think what the VA does in those programs is good and it is helpful, but I think they also have to be expanded. But maybe other types of nondirect medical care might need to be addressed.

Mr. EVANS. I find that is being done on a piecemeal basis. I think, as Mr. Adelman said, we need some kind of national plan which includes some of these components as part of how we deal with the needs of the aging veteran. It is left to the discretion of each Medical Director, and because of some of the cuts that they have had to make, some of those programs have faced cutbacks or temporary cutbacks.

Commander?

Commander WANAMAKER. You mentioned respite care, and I have an example here in a letter dated March 29. A lot of this crosses my desk on a continuing basis, and that is why this hearing, when it came up, I was so anxious to get over here and tell you.

This letter is from a couple that had been using the respite care at the VA facility at Menlo Park. They both are 73 years old. Her husband, a reserve officer—was a World War II veteran—had Parkinson's disease. That debilitating disease, there is no cure for it, and she had been trying to take care of him at home. But the res-

pite care allowed her one time during the year to go to the VA and get assistance for $520. Since that time, the VA respite care facility wrote her a letter and said, "Sorry, you are Category C. You can't come any more." They are not only going to let this guy suffer but they are going to kill his wife, too. She can't handle it. She needs respite care. It is just as simple as that.

Now, you say, Well, okay. She has $20,000. They are married and should be eligible for this. She says she can't afford it. All she says is, Please, please, anything, but don't cut out that care.

Mr. EVANS. I think you gave very human examples of what is happening. The subcommittee, Mike and I, were recently in San Diego, at the invitation of Congressman Jim Bates. They have just cut out respite care there. We are seeing this as a nationwide trend. You mentioned the disenfranchising of Category B and C veterans. The notices the Iowa City Medical Center is giving people are very hard for, I think, some folks to comprehend. They feel they are being cut loose. Some of the more elderly people who are cut loose don't have anybody there, really, to walk them through the system, to even tell them that they could come back if their situation gets worsens. They are being released when they are stable. They are not told that they may come back if their income deteriorates because of the means test. The amount of money some spent of on the medication is going to almost guarantee that their income is going to deteriorate.

We are really dependent upon the veterans organizations and I think you are doing a fine job dealing with the human cost. I want to commend DAV for their home assessment program for successful aging. I know that you have raised a great deal of money, particularly through the DAV charities in LA. I think that is a commendable program. But we do have to view this as, I think, a largely Federal responsibility. Whether it is DAV or the AMVETS starting innovative programs, that is fine, but we have to maintain Federal responsibility.

Let me recognize my colleague from Florida for any questions or comments he may have.

Mr. STEARNS. Thank you, Mr. Chairman. I just wanted to sort of touch a little bit on what you mentioned about the home visitation program, and ask Mr. Gorman, who just mentioned it. It was in my brochure here and I read a little portion of it.

The visitation program is of great interest to me. I have a lot of disabled Americans that say what can I do and what can I do, so this would fall into that line. Is a person actually given a medical physical, and who pays for that under this program?

Mr. GORMAN. Right now, Mr. Stearns, we started the program in July of 1988 and it really hasn't launched itself except in the last couple of months. So it is relatively new and we are trying to feel our way through it. In conjunction with the GRECC out there, they have been able to get some volunteer workers, who are health care professionals but retired, to go out to the patient's home and, yes, do the type of things you are indicating should be done; that is, the physical and mental assessment. Dietiticians are also involved. Hopefully, the end goal of all of this would be to work in conjunction with the VA hospital in the local area. We are going to hopefully expand this, by the way, to at least two more sites in the near

future. But, from that initial evaluation point, sort of back off the health care professionals and use trained volunteers, and that could be DAV volunteers, or VFW volunteers, or Legion volunteers that just would volunteer who have some kind of specialized skills, and it does not necessarily have to be in health care. It could be in carpentry to repair things around the house or anything along that line.

So, yes, I think the first step is the health care evaluation, per se, and then sort of back off of that and just use the volunteers in a regular maintenance-type program.

Mr. STEARNS. So right now the real medical examination of the individual is done by volunteers or is done by doctors?

Mr. GORMAN. No, it is done by some of the GRECC staff.

Mr. STEARNS. So the staff goes out the home or does the individual come in?

Mr. GORMAN. They will go out to the home.

Mr. STEARNS. And do a physical examination.

Mr. GORMAN. At the same time in the process of training volunteers, who are also health care professionals but primarily retired, to do the same thing and what to look for in the geriatric patient. Also, and I am afraid it is slipping my mind what they are referred to, but there is a lot of concern about those actual obstacles and dangers in the home itself that should be removed, that are potential hazards for falls or other kinds of accidents. Simply removing those, maybe with some type of an engineer who could go out and look at that, that that also could be very beneficial.

Mr. STEARNS. I just want to encourage you with that program. I think, as one member of the committee, and I know the chairman probably, all information on it, the monies involved and how it is progressing is of keen interest to me, just because I hear so many veterans, disabled veterans saying "What can I do?" and if I had this pilot program, I would be glad to try it out in our area through our veterans hospital, which is at Gainesville, at the University of Florida. I am just excited to read about it, and I will keep in touch.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. I thank my colleague for coming. If he has an opening statement that he would like to submit, we would welcome it too.

Mr. STEARNS. For the record, I would like that privilege.

[The prepared statement of Congressman Stearns appears on p. 46.]

Mr. EVANS. I thank the panel for coming and giving so much of your time.

This concludes our hearing. I think I can speak for all members of the committee, both the subcommittee and the full committee, that this will be of continuing interest and concern and a focus of the committee's attention at hearings and site visits in the years to come. I know as a veteran myself who turns 65 in the year 2016 that I have some vested self-interest in this issue. We thank you all again for coming today.

The hearing is concluded.

[Whereupon, at 11:58 a.m., the subcommittee was adjourned, to reconvene subject to the call of the chair.]

APPENDIX

STATEMENT BY THE HONORABLE DOUGLAS APPLEGATE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

APRIL 13, 1989

HEALTH CARE SERVICES FOR AGING VETERANS

THANK YOU, MR. CHAIRMAN. I WANT TO THANK YOU MOST OF ALL FOR DECIDING TO HOLD THIS IMPORTANT HEARING. THE ISSUE OF AMERICA'S AGING VETERAN POPULATION WILL OCCUPY THE ATTENTION OF CONGRESS AND THE NATION FOR SEVERAL DECADES TO COME.

THIS ISSUE IS NOT TOTALLY UNANTICIPATED, HOWEVER. ABOUT FIVE YEARS AGO, THE VETERANS ADMINISTRATION, NOW THE DEPARTMENT OF VETERANS AFFAIRS, ISSUED THEIR REPORT, "CARING FOR THE OLDER VETERAN." MUCH OF WHAT WAS CONTAINED IN THAT REPORT WILL LIKELY BE REPEATED HERE THIS MORNING, SUCH AS THE FOLLOWING, STRIKING STATISTICS:

THE NUMBER OF VETERANS OVER THE AGE OF 65 WAS 10.5 PERCENT IN 1980. FIVE YEARS AGO, IT WAS PROJECTED TO INCREASE TO 26.6 PERCENT IN 1990;

IN THE YEAR 2000, 9 MILLION VETERANS WILL BE OVER THE AGE OF 65, TRIPLE THE NUMBER OVER 65 IN 1980;

OF EVEN GREATER CONCERN, THE NUMBER OF VETERANS OVER THE AGE OF 75, ROUGHLY 859,000 IN 1980, WILL INCREASE TO NEARLY 4 MILLION AT THE TURN OF THE CENTURY, REPRESENTING AN INCREASE OF 445 PERCENT;

AND, WHILE THE OVER ALL PERCENTAGE OF VETERANS OVER THE AGE OF 75 WAS ONLY 3 PERCENT IN 1980, IT WILL LIKELY REACH MORE THAN 21 PERCENT IN THE YEAR 2010.

ALTHOUGH THE OVERALL NUMBER OF VETERANS WILL CONTINUE TO DECLINE THROUGHOUT THE FUTURE, BARRING UNFORESEEN EVENTS, THE REAL CRUX OF THE PROBLEM FACING US IS BEST CHARACTERIZED AS A DOUBLE WHAMMY OF A RAPIDLY INCREASING NUMBER OF OLDER VETERANS, THE VERY SEGMENT OF OUR VETERANS WITH THE GREATEST HEALTH CARE AND MEDICAL NEEDS, AS WELL AS NURSING HOME AND DOMICILIARY CARE, COMBINED WITH THE GLARING FACT THAT THESE ARE THE MOST EXPENSIVE AND INFLATIONARY AREAS OF SPENDING BY THE NEW DEPARTMENT. UNLIKE NEARLY ANY OTHER COMPONENT OF FEDERAL SPENDING, THE PROBLEM FACING US IS AN ALREADY DETERIORATING MEDICAL AND HEALTH CARE SERVICE COMING AT A TIME WHEN GREATER NUMBERS OF ELIGIBLE RECIPIENTS WILL BE MAKING DEMANDS UPON THESE SERVICES.

QUITE FRANKLY, THE SOLUTIONS ARE NOT TO BE FOUND IN MORE STUDIES AND EVALUATIONS. WE KNOW WHAT NEEDS TO BE DONE; WE KNOW THAT UNLESS WE WISH TO WITNESS LITERALLY MILLIONS OF AGED VETERANS FACE UNFILLED MEDICAL NEEDS AND A LACK OF NURSING HOME BEDS, THEN WE MUST EMBARK TODAY - NOW - TO PLAN AND PREPARE FOR THIS CHALLENGE. THE WAY IN WHICH WE RESPOND TO THIS GROWING CRISIS WILL BE JUDGED BY FUTURE GENERATIONS AND BY THE MEN AND WOMEN IN OUR MILITARY WHO WILL SOMEDAY BE IN NEED OF MEDICAL AND NURSING HOME CARE.

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MR. CHAIRMAN, REPUBLICAN AND DEMOCRATIC COLLEAGUES, REPRESENTATIVES OF THE DEPARTMENT OF VETERANS AFFAIRS, AND VETERANS. WE ARE HERE TODAY TO HEAR TESTIMONY REGARDING THE PRESENT AND FUTURE STATE OF HEALTH CARE SERVICES FOR OUR AGING VETERANS.

THE MEDIAN AGE OF THE VETERAN IS APPROXIMATELY 56 YEARS OLD. OF THE 27 MILLION VETERANS, THOSE WHO ARE OVER 65 COMPRISE 22% OF THE VETERAN POPULATION. THIS FIGURE WILL RISE SHARPLY OVER THE NEXT TEN YEARS.

AS THE POPULATION GROWS OLDER, THE NEED TO PROVIDE ADEQUATE HEALTH-CARE SERVICES WILL GROW RIGHT ALONG WITH THEM.

VA MEDICAL CENTERS IN FLORIDA AND ACROSS THE NATION ARE EXPERIENCING AN INCREASE IN THE USAGE OF OUTPATIENT AND EXTENDED CARE FACILITIES AS WELL AS A DRAMATIC INCREASE IN VA-PAID NURSING HOME CARE. THE STATISTICS CANNOT BE IGNORED. THE NEED CANNOT BE DENIED.

THE CHALLENGES THAT FACE THE VA ARE MANY AND VARIED. BUT NONE IS GREATER THAN THAT OF DEVELOPING AND MAINTAINING ADEQUATE HEALTH-CARE SERVICE. THE VA IS EXPERIENCING SHORTAGES IN NURSING HOME CARE, LONG-TERM CARE, AND ACUTE CARE. ALL OF WHICH WE MUST BE ADDRESS. THESE PROBLEMS HAVE BEEN NEGLECTED TOO LONG AND VETERANS ARE PAYING THE CONSEQUENCES.

WE CAN NO LONGER DELAY. THE PROBLEMS THAT FACE THE VETERAN ARE NOT INSURMOUNTABLE. WE CAN FIND THE SOLUTIONS. WE NOW MUST EXAMINE THESE PROGRAMS, AND FIND THE BEST WAY TO PROVIDE BETTER HEALTH-CARE SERVICE FOR THOSE MEN AND WOMAN WHO SERVED AND SACRIFICED FOR THIS NATION SELFLESSLY, WITH PATRIOTISM, COURAGE, AND HONOR.

TESTIMONY OF REP. JAMES J. FLORIO
(D--NJ)

BEFORE THE VETERANS' AFFAIRS SUBCOMMITTEE

ON OVERSIGHT AND INVESTIGATIONS

HEALTH CARE SERVICES FOR THE AGING VETERANS

APRIL 13, 1989

Chairman Evans, thank you for the opportunity to testify this morning as we renew the effort to look at the health care needs of the aging veteran. I would like to commend you for scheduling this hearing and, as a member of this subcommittee, I welcome the opportunity to work with you to address this important problem.

Throughout our history, brave men and women have been only too glad to answer this nation's calls to serve. They had a commitment to their country. And their country made a commitment to them in return. A commitment to provide veterans with top quality health care -- a commitment to 'care for him who shall have borne the battle, and for his widow, and his orphan.' This has become the motto of the Department of Veterans' Affairs.

But it is this commitment that is in danger of being broken. And it couldn't come at a worse time. It is a fact of life that the older we get, the more likely we are to need health care. Today, the very youngest World War Two veterans are 61 years old. Yet, just as the nation's largest group fo vets is heading into the years of peak medical need, we are running a Veterans' Department that has been battered by budget cuts and by serious doubts as to its ability to provide quality treatment.

This past September, I brought the House Aging Subcommittee on Health and Long-Term Care to New Jersey to take testimony from veterans in my district who are a part of this group of aging veterans. Mr. Chairman, unfortunately, we had no difficulty in finding veterans and their families only too willing to talk about the shortcomings of veterans facilities in dealing with the needs they face.

I heard compelling testimony from a Navy veteran who served his country for 30 years. But when he turned to the VA for his extensive medical problems, in his words, "he lost faith" in the VA health care system. When he needed immediate hospitalization for a possible tumor in his kidney, he was told by the VA that he would have to go the nearest VA hospital in Philadelphia, an hour and one half away from his home. When he got to the hospital at 3:30 in the afternoon, he was told that he needed to see a urologist. Well, a urologist was not available and he was sent home bleeding. When he saw the urologist the next day, again in Philadelphia, he was told that he should go home, bleeding, and come back in one week for more tests. Two days later, he checked into the nearest civilian hospital for emergency surgery after getting approval from the VA.

His troubles were not over. The night before his surgery, our veteran who served his country for 30 years, was transferred by ambulance, still bleeding, back to the VA hospital that had sent him home. However, he was sent to have more tests done at another private hospital. Since transportation to that hospital was not forthcoming from the VA, our veteran took a taxi in his bathrobe.

Mr. Chairman, my constituent was operated on at the VA Hospital one month after he had started bleeding and a 5 1/2 pound tumour was removed. My constituent did not tell his country to wait around for a month when he was called to serve in World War Two. This type of treatment is unacceptable.

There is no end to the problems elderly veterans are encountering within the VA system. Just last week, I held a hearing through my Subcommittee on Commerce, Consumer Protection and Competitiveness on the Medigap policies our seniors are buying to protect them from the high costs of health care. One of our witnesses was another World War Two veteran who had become a victim of these Medigap policies. For him, the closest VA facility that he would go to was in Wilmington, Delaware. When he had a minor heart attack some time ago, he checked into the closest private hospital. When he learned that it would cost him 320 dollars per day, he checked right out and went home.

Because he failed to get adequate medical care, he suffered a massive heart attack later on. This time, he was taken to the Wilmington VA Hospital where his care was free. What disturbed me about this situation was that this veteran did not even know that he could get free medical care because of his service. Because he didn't know this, he had gone out and bought an expensive and unnecessary Medigap policy to pay for whatever costs Medicare would not cover.

Mr. Chairman, these are real-life anecdotes that illustrate the needs our aging vets are facing. Make no mistake about it, America is growing grayer. By the year 2000, the number of veterans 65 and older is expected to triple, to some 9 million. Studies show that we would have to open a 200-bed nursing home every day between now and the year 2000 to meet that need. In terms of regular hospital beds, we will need a 25 percent increase. We need more resources for home care, for respite care, for nursing home and for acute care.

Instead, the VA is cutting back with sometimes disastrous results. Not long ago, this Committee released a troubling report showing that not only is the VA failing to increase service, but it actually has put 13,000 beds out of service across the nation. My area has been especially hard hit. Over a year ago, a man died last year at the Coatesville, PA facility because there wasn't enough staff to prevent a serious mistake. But this facility has been cut by more than half. Beds available to veterans for health care at Lyons and East Orange have been put out of service and off limits for lack of staff.

Across the country, 20,000 veterans each month are refused care. They are turned away because there is no room, or not enough staff. For others, care comes only after long waits and long lines.

I hope that when this hearing is finished, we will have a better understanding of not only the problems our senior vets are facing and will face but also of some possible solutions to deal with these problems. Our veterans are proud people -- and they have a lot to be proud of. They put their lives on the line for their country. It isn't too much to ask that, in their advancing years, we treat them with dignity and respect.

STATEMENT OF

DANIEL H. WINSHIP, M.D.

ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

APRIL 13, 1989

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before this Subcommittee to discuss health care needs of aging veterans and the Department of Veterans Affairs' extended care programs.

The health care needs of aging veterans are not different from those of the aging population at-large except that, at this time, the aging veteran proportion is far higher than that of the general population. The compelling demographics of the aging veteran population are well known to this Subcommittee. Over the past ten years, the number of aged veterans has doubled. The overall number of veterans in the United States will steadily decline from 1990 to 2020, (27 million to 17 million). Conversely, the number of aged veterans will continue to increase from slightly over 7 million to nearly 8 million over the same period -- peaking in the year 2000 at nearly 9 million veterans.

Mr. Chairman, we have experienced a dramatic surge in demand for health care services for elderly veterans in the past decade. We expect this demand for services to continue at the same rate experienced today as the elderly population increases in the future. The health care needs of this group range from acute inpatient care to long-term care, both institutional and non-institutional, and to community-based care. However, the utilization of health care services by the elderly veteran is disproportionately greater than use by young veterans. For example, veterans aged sixty-five and older make-up 24 percent of the total veterans, but account for 38 percent of acute hospital admissions, 34 percent of outpatient visits, and 72 percent of nursing home placements.

As the population ages, and although acute inpatient care is vital to elderly veterans, acute short-term medical episodes are overtaken increasingly by long-term care stays. The VA is a national leader in the delivery of long-term care, providing to eligible veterans a broad continuum of health care services. These programs range from the most intensive intervention, found in the nursing home care programs, to the least intensive, the community residential care home program. At the most intensive level, medical and nursing services predominate. At the least intensive level, health related and social support services become more essential.

Let me briefly review the scope of these long-term care programs as of the close of FY 1988. The VA provides nursing home care for aging veterans under three programs: VA, community (contract), and State Home. The VA operated 119 nursing home care units providing care to an average daily census of nearly 11,500, and served over 27,000 patients in VA nursing home care units during the year. The community (contract) program served an average daily census of 12,400 in 3,600 nursing homes in 50 states and Puerto Rico, and treated over 42,000 veterans. In the State Home program, the VA provided per diem payments to 50 state nursing homes in 30 states, providing care to an average daily census of nearly 9,000 veterans and to more than 14,000 annually.

The Domiciliary program, which provides long-term rehabilitation and health maintenance to veterans, accounted for an average daily census of over 6,000 and treated over 16,000 veterans in 27 domiciliaries. In late FY 1987 and FY 1988, the VA opened 10 new domiciliaries in urban areas and also enhanced the services of 10 existing domiciliaries to serve the needs of homeless veterans.

In the State Home Domiciliary program, the VA provided per diem assistance to 43 State domiciliaries in 32 states, serving an average daily census of over 4,000 and treating nearly 7,500 veterans.

In order to provide the most appropriate level of care, the VA has developed several alternatives to long-term care institutionalization. These include Hospital Based Home Care, Adult Day Health Care and Community Residential Care. The Hospital Based Home Care program employs an interdisciplinary team of VA staff to deliver primary medical care to homebound patients by providing professional care, supervision and instruction in nursing procedures and daily care. This program is currently in operation at 73 medical centers.

Adult Day Health Care provides health maintenance and rehabilitative services to frail individuals in a congregate setting during daytime hours. This program is designed to provide an alternative to unnecessary institutionalization and to delay premature institutionalization. This program is currently under study to determine its medical efficacy and cost-effectiveness as an alternative to nursing home care. A report of this study will be provided to the Congress in January 1991.

The Community Residential Care Home program provides room, board, and limited personal supervision (at the veteran's own expense) along with home visits by VA social workers and nurses and outpatient care for the veteran. In FY 1988, the VA utilized nearly 3,000 homes in this program serving an average daily census of over 11,000.

In FY 1987, the VA began implementation of an institutional respite care program. This program allows eligible veterans to receive inpatient care for up to 30 days per calendar year in order to provide relief to the caregiver. The duration of any one admission will not exceed 14 days. During FY 1988, respite care programs were in operation at 88 medical centers. The health efficacy and cost-effectiveness of this program are also under study and a report of the study will be provided to the Congress by February 1990.

Of increasing importance to the most appropriate utilization of all of the above programs, and to acute medical intervention as well, is the Geriatric Evaluation Unit program. This program, operating at 87 medical centers, provides an interdisciplinary approach to comprehensive diagnosis, treatment, and discharge planning for elderly patients who typically have multiple medical and psychosocial problems.

In nursing home care, VA's planning efforts are aimed at serving 16 percent of the estimated 290,000 veterans who will need nursing home care in the year 2000. These plans are focussed on delivering care to some 46,000 veterans on any given day through the three VA-sponsored nursing home programs: VA Nursing Home Care Units (VANHCU); Community Nursing Homes (CNH); and State Nursing Homes. Of the some 46,000 veterans, it is the VA's plan to provide care to 30 percent of the veterans in VANHCUs; 40 percent of the veterans will be treated in the CNH Program; and 30 percent will be treated in the State Home Program.

Through FY 1988, the VA had already reached 70 percent of its year 2000 goal for nursing home care. VANHCUs had reached over 80 percent of its workload goal; the CNH Program had reached nearly 70 percent of its goal; and the State Nursing Home Program had reached over 60 percent of its year 2000 goal. In the Domiciliary Care Program, a new needs assessment model has been applied to measure the need for this level of care. The results of the first application of the model are expected this summer. We will be in a better position to project the need for domiciliary care following our analysis of the model's application.

The VA will continue to maintain a broad-based, active strategy to meet the long-term care needs of the aging veteran population. Critical elements of our strategy include program growth, reliance on community and state home programs, converting hospital beds to nursing home beds, gradual expansion of noninstitutional programs, initiatives in community residential care and use of other community resources, and geriatric assessment.

Mr. Chairman, I would now like to turn to the VA's Geriatric Research, Education and Clinical Centers (GRECCS). The VA initiated a strategy in the early 1970s to focus attention on the aging veteran population by increasing the basic knowledge of aging, transmitting that knowledge to health care providers, and, improving the quality of care to the aged. One aspect of the strategy was the development of Geriatric Research, Education and Clinical Centers (GRECCs), the first of which were established in FY 1975. The GRECCs are centers of excellence designed for the advancement and integration of research, education and clinical achievements in geriatrics and gerontology in the total VA health care system.

Based on a variety of indicies, the impact of the GRECC program in the national and international aging-related research community is significant and increasing. Since FY 1984, while the number of GRECCs has remained constant at 10, peer review funding awarded GRECC staff has increased from nearly $11.6 million to over $20.5 million - a 62 percent increase after accounting for inflation. Furthermore, GRECCs have become increasingly competitive in obtaining peer review funds from sources other than the VA. In FY 1984, 58 percent of peer review dollars were non-VA monies, while the current percentage is over 70.

GRECC investigators are recognized nationally and internationally for their achievements. Their work directly influences the provision of care for elderly persons.

The GRECCs provide a model for the integration of research, education and clinical care. They disseminate research, clinical care knowledge and other geriatric and gerontological knowledge through continuing education activities and through the provision of training to Geriatric Fellows, residents, nurses and other associated health trainees. GRECC continuing education offerings demonstrate a rich variety of gerontological topics. Some programs being offered in FY 1989 include: Cardiovascular Health and Disease in Older Adults; Current Research and Clinical Applications; Creative Coping with Caregiving Issues; Clinical and Policy-Making Arenas; Management of Infections in the Elderly; and Geriatric Practice in the Outpatient Setting.

Continuing education programs given by GRECCs each year are attended by physicians, nurses and allied health professionals from VA medical centers in the respective GRECC's region. GRECCs frequently co-sponsor their programs with the affiliated university to broaden the target audience to include community health care providers. In addition to continuing education conferences, GRECC staff provide lectures, seminars, case conferences and teaching clinical rounds at their host VA medical centers as well as lectures and training at other VA medical centers and in the community.

One very important clinical achievement of the GRECCs has been the development of a geriatric evaluation and treatment program. The first Geriatric Evaluation Units (GEUs) were established at the Little Rock and Sepulveda GRECCs as clinical demonstration models in the mid to late 1970s. In a landmark randomized, controlled study done at Sepulveda and published in The New England Journal of Medicine in 1984, the GEU was found highly successful in improving patient care outcomes, including decreased mortality, decreased discharge to nursing homes, lower rehospitalization rates and lower cost of care over a one year follow-up period. All 10 GRECCs have subsequently developed GEUs and continue to evaluate the effectiveness of different models: inpatient, outpatient and consultation teams. Throughout the VA system, 87 medical centers currently have geriatric evaluation programs.

Other clinical demonstration programs developed by GRECCs include dementia study units, academic nursing homes, geriatric intensive care units and multiple, specialized outpatient programs, such as clinics for elderly patients with cancer, osteoporosis, falls and sleep disorders.

Dissemination of information from GRECC activities is of critical importance. One of the primary goals of the Office of Geriatrics and Extended Care is to increase the accessibility to and utilization of GRECCs by other VA medical centers for consultation on patient management, clinical and educational program development and research assistance.

Finally, Mr. Chairman, the VA has been and will remain a leader in the provision of quality long-term care services to eligible veterans as was most recently documented in a program evaluation of our nursing home care programs, conducted by Price Waterhouse. We have developed a model continuum of care. We have sought and will continue to refine the balance between acute and long-term care as well as between institutional and noninstitutional care. We are committed to efficiency in our program operations. We will search for and, when feasible, test appropriate new modalities of service delivery. Through such means as careful patient placements, appropriate discharge planning, and improved operations, we hope to meet the goal of providing needed, quality acute and long-term care services to the aging veteran population. In all, we will strive to preserve our excellence in the delivery of care.

Mr. Chairman, this concludes my remarks. I shall be pleased to answer any questions you or members of the Subcommittee may have.

STATEMENT OF CONGRESSMAN CLIFF STEARNS

HOUSE COMMITTEE ON VETERANS AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

APRIL 13, 1989

Thank you Mr. Chairman for the opportunity to be a part of this hearing today.

We are meeting today to discuss the need for expanded health care services for our aging veteran population. Our nation as a whole is getting older, and the services necessary to provide medical care for Americans will change drastically over the next two decades. Geriatric medicine is undoubtedly the specialty of the future.

Of particular interest to this committee is the effect of the "graying of American" on services for veterans. The fighting men and women of the 1940s are the retirees of the 1980s and 1990s. These World War II combat veterans are at the stage where medical and geriatric services are most crucial. Unfortunately, the nation is at a point where expenditures in every area of government are being scrutinized and, in most cases, reduced. In my estimation, the timing for further cuts in veterans' services could not be worse.

In Florida, the national problem of aging veterans is magnified. As you know, my state is a popular destination for retirees, and the senior population there is the fastest growing in the country. The need for health care services for these people is phenomenal. Our Veterans Administration Medical Center in Gainesville is always filled with patients, yet it recently had to close 71 medical and nursing home beds because of fiscal problems. I know that situation is not unique in Florida or other sun belt states. We need to give adequate resources to these medical programs.

Nursing home space is also a problem. In a study conducted by the VA, it was estimated that the need for nursing home beds in Florida would be 2688 by 2000. Currently there are only 810 beds in the state. We must address the lack of long-term chronic health care facilities across the country for those veterans who need this special type of health care.

One outstanding program which has been developed by the VA is the Geriatric Research Education and Clinical Centers program which has pioneered research in geriatric medicine in medical centers across the country. The GRECCs have been successful in physician training and continuing education of VA professionals and other health care providers. Congress must fully fund these programs and expand them to cover the growing need.

In conclusion, I would like to reiterate that while the state of Florida does have special needs, the needs of veterans all over America must be addressed. Our biggest group of veterans is of retirement age, and they comprise a large percentage of health care consumers. We must make sure that medical care for them is readily available.

Thank you Mr. Chairman.

TESTIMONY

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

PUBLIC HEARING ON ELDERLY VETERANS

APRIL 13, 1989

Richard C. Adelman, Ph.D.
Chairman, Geriatrics and Gerontology Advisory Committee,
Department of Veterans Affairs
and
Director, Institute of Gerontology
The University of Michigan

Mr. Chairman and Distinguished Members of the Committee:

INTRODUCTION

My name is Dr. Richard Adelman. I am the Director of the Institute of Gerontology at The University of Michigan; a recent Past President of the Gerontological Society of America; and the current Chairman of the Congressionally established Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs. My testimony today should be regarded as representative of the views of the community of scholars who are committed to the study of aging and its impact on the veterans population.

The problems of aging in the U.S. today have reached center stage. The explanation of its prominence very simply is based on the numbers of people involved. The percentage of Americans who are older than 65 years has increased from 4% in 1900 to more than 12% today, and will exceed 20% within the next few decades. The increased proportion of elderly people in the U.S. population already is in the process of profoundly changing the very fabric of our society from the delivery, costs and ethics of health care, to the composition of the workplace and the classroom, and to the targets of our advertising enterprise.

We are here today, however, because the increased proportion of elderly people in the total U.S. population pales in comparison with that of the veterans population. The percentage of veterans who are older than 65 years already is 20% of the total veteran population, and in less than ten years will reach the staggering proportion of more than 35%. Thus, it is an ironic reality that those who already have defended us in battle now must represent the vanguard of the aging of America.

I am pleased to report that the Veterans Administration could boast a long and distinguished history of pioneering efforts in the care for the elderly. One particularly notable example of such efforts is the Congressionally mandated establishment of the national network of centers of excellence known as the Geriatrics Research Education and Clinical Centers (GRECCs). For example, in

these centers of excellence originated such exciting and important programs as the Geriatric Evaluation Units, Teaching Nursing Homes, and so forth. The GRECCs are training sites for physician fellows and converted faculty, as well as continuing education of practicing physicians and other health professionals within and beyond the Veterans Hospitals. Furthermore, the leadership of the GRECCs almost without exception is responsible for the ongoing development of geriatric medicine throughout the medical schools of the U.S. For example, when the decision was made five years ago to launch a major initiative in geriatric medicine at my own institution, The University of Michigan, one of our earliest steps was the recruitment of faculty leadership by stealing the appropriately talented physician scientist from one of the already funded GRECC programs of the Veterans Administration. Today geriatric medicine is so well established at The University of Michigan, in collaboration with the Ann Arbor Veterans Hospital, that the Chairman of our Department of Medicine within the past few weeks announced the commitment to six new faculty positions in an already thriving Division of Geriatric Medicine.

PERCEPTION OF PROBLEMS AND RECOMMENDED ACTIONS

In glaring contrast to this distinguished history, however, the Department of Veterans Affairs presently is not prepared to care for its rapidly growing population of aging veterans. I perceive three major difficulties. I shall summarize each of these problems briefly, and follow each of the summaries with recommendations for Congressional actions.

1) The present authority of the Department of Veterans Affairs is too narrow and too restricted to address the full spectrum of needs of elderly veterans. For example, acute medical care is over-emphasized and long term care is under-emphasized. Furthermore, the Department is unable to support adequate care in the necessary social context, such as from the perspective of community-based services which are available to elderly non-veterans. The kinds of services most desperately needed by elderly veterans, although innovatively demonstrated by a modest number of select model programs in the

GRECCs, are in greatest jeopardy in these times of fiscal crisis because the importance of these programs is not recognized by the leadership of most of the national network of Veterans Hospitals, by Central Administration, or by Congressionally mandated entitlement.

My general recommendation for Congressional action is as follows:

Empower the Assistant Chief Medical Director for Geriatrics and Extended Care at Central Office with additional support staff and authority, as well as with reallocation of existing Departmental funds, to establish and to regulate formal, Congressionally mandated programs in Geriatrics and Extended Care at every Veterans Hospital.

This is a complex matter. Needs vary immensely by geographic region and from hospital to hospital. The availability of Departmental services must be initiated, coordinated and/or integrated, in many cases for the first time, with relevant community-based services, facilities and agencies. For example, long term care is not presently a Congressionally mandated entitlement in Veterans Hospitals. Changes must be phased carefully to coincide with the availability of adequately trained personnel. The Geriatrics and Gerontology Advisory Committee should be charged with the assignment to assist the Offices of Clinical Affairs and of Geriatrics and Extended Care, in cooperation with those Departmental Offices responsible for the delivery of services by all other health professionals, in the development of appropriate plans.

2) There is insufficient knowledge and expertise among most personnel at Veterans Hospitals to provide necessary care for even the current population of elderly veterans. The overwhelming majority of physicians and other service providers at Veterans Hospitals have not received training in geriatrics. Most Veterans Hospital Directors, as well as most personnel in Central Administration, are not sufficiently sensitive to the most pressing policy issues.

My general recommendation for Congressional action is as follows:

Reallocate existing Departmental budget for enhanced regional training activities by the existing GRECCs; funding of the two recently authorized and selected GRECCs; and selection and funding of some

negotiable number of the remaining thirteen authorized, but unselected GRECCs.

Already existing mechanisms for residency and fellowship training, career development, and continuing education should be applied to the accelerated promotion of opportunities in geriatrics and long term care, using established GRECCs as regional training sites. The Geriatrics and Gerontology Advisory Committee should be charged with the assignment to assist the Offices of Academic Affairs and of Geriatrics and Extended Care in the development of appropriate plans.

3) There is not enough money to continue to care for the elderly in the presently prescribed manner. The present patient care budget will not be able to absorb the growth in the proportion of the veterans population older than 65 years. The 20% of the veteran population which is older than 65 years of age presently accounts for 35%-45% of the patient care budget. Furthermore, the cost of present medical care per older veteran exceeds that of the younger veteran on an individual basis. It follows that in less than ten years less than one half of the veteran population could account for all of the patient care budget, assuming that the present budget, menu of services, and medical costs remain constant.

My general recommendation for Congressional action is as follows:

Increase the research budget in a manner specifically designed to encourage investigators of all kinds throughout the Veterans Hospitals to apply their expertise to the more sophisticated understanding of aging.

The failure to invest new monies in research is penny-wise and dollar-foolish. Alleviation of current service needs certainly requires reallocation of existing resources as quickly as possible. However, the history of medical science teaches that the earlier the investment in basic biological understanding, the sooner disease is abolished. To reiterate a most popular example, it was the decision to pursue the understanding of immune response and of virus action rather than to build bigger and better iron lungs that brought about the eradication of polio. Crucial research problems in

geriatrics currently range from the neurology and genetics of Alzheimer's Disease, to the endocrinology and metabolism of diabetes, to the identification and treatment of elderly veterans who are homeless or afflicted with AIDS or chronic mental illness, to the improvement of health service delivery, to the establishment of functional deficit rather than politics as the basis for eligibility of treatment, and so forth. Mechanisms to enhance the pursuit of aging-related research might include research career development awards, special funding set-asides, special research merit review groups, long term funding periods, increased flexibility of entitlement programs for human subjects, replacement of deteriorating GRECC laboratory equipment, and so forth. The Geriatrics and Gerontology Advisory Committee should be charged with the assignment to assist the Offices of Research and of Geriatrics and Extended Care in the development of appropriate plans.

CONCLUDING REMARKS

The Department of Veterans Affairs is poised at a pivotal moment in the history of care for the elderly. For more than twenty years, scholars and service providers from within and outside the veterans community have been warning us that a tidal wave of elderly people is about to overwhelm the existing service delivery systems. That tidal wave already has reached our shores. Thanks to the presence of such Congressionally mandated centers of excellence as the GRECCs, successful model programs of patient care, education and research now exist. The time has come for the Department of Veterans Affairs to adopt these model successes and to integrate them into the mainstream of activity. It is quite apparent that Congressional mandate is the signal which the leadership of Central Administration awaits. I respectfully urge you to oblige them.

It is noteworthy that my recommendations for Congressional action emphasize the reallocation of the existing budget of the Department of Veterans Affairs, rather than the traditional request for additional Congressional appropriations. This seemingly heretical avoidance of potential Congressional generosity is based upon each of two contemporary realities. First and foremost, in these times of fiscal constraint it should be regarded as an

inherent responsibility for every federal agency to contribute to the reduction of the federal deficit. Secondly, the Congressionally mandated prioritization of geriatrics by reallocation of existing budgets delivers the unmistakable message that the status quo is not good enough to respond to the needs of aging veterans. By all means, individual Veterans Hospitals should be encouraged to continue to do what they do best, but in the updated context of the application of geriatrics to aging veterans.

The problems and recommendations included in my testimony today are far too complex to allow detailed discussion at this time. However, I wish to alert you to a meeting of the Geriatrics and Gerontology Advisory Committee in the conference room space of the House of Representatives Committee on Veterans' Affairs on Thursday, April 25. The topic of this meeting is Options for Policy Change in the Care of Elderly Veterans. Drs. Gronvall and Yoshikawa, a representative of the Veterans Service Organizations, and I are among the invited speakers. Members and staff of the Committee on Veterans' Affairs are cordially invited to attend and to participate in the discussion. The content of these presentations and ensuing discussions will be included in a report which offers specific and detailed recommendations for policy change in the care for elderly veterans and which is scheduled for delivery to Congress and to the Department of Veterans Affairs within the next few weeks.

Thank you very much for this opportunity to testify.

Richard C. Adelman

Richard C. Adelman, PhD
Chairman
Geriatrics and Gerontology Advisory Committee

/rps

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 13, 1989

Mr. Chairman and Members of the Subcommittee:

The American Legion is pleased to take this opportunity to present its views on a number of issues that relate to the health care requirements of the nation's aging veteran population.

The Department of Veterans Affairs' programs for aging veterans are extremely important, and we commend the Subcommittee for examining this subject, so as to ensure that the VA not only is providing appropriate treatment and services for the aging veteran population today, but is also planning to increase and expand these programs in the future, as the needs escalate.

The American Legion has a very clear mandate relating to the health care needs of aging veterans set forth in Resolution No. 247, adopted by the Delegates to the 1988 National Convention. The resolution places us in the position to urge the VA to prepare and submit to the Congress a comprehensive plan that would detail its proposal to deliver health-care and related services to the aging veteran, and we have done so.

The American Legion is very much aware of the potential problems associated with the impact of the aging World War II generation on Department of Veterans Affairs' services. These problems need to be seriously addressed.

We have continually testified in support of proposals relating to alternatives to long-term hospitalization and nursing care for veterans during hearings scheduled by the Veterans Affairs Committees over the past several Congresses.

As a result of legislation, recommendations by the VA Geriatric and Gerontology Advisory Committee, and breakthroughs in the area of geriatric medicine, the VA is in the process of developing an extensive array of services for the aging veteran.

Unfortunately, the percentage of VA physicians possessing board certification in gerontology is small in comparison to the demand. We understand that this is a problem in the private sector also. However, as medical school affiliates continue to modestly expand the residency training programs in the field of geriatrics, VA must prioritize resources to meet its needs in this area. The further expansion of VA's Geriatric Research, Education and Clinical Centers (GRECCs) will promote the recognition of the

role of geriatric medicine in today's society to a certain extent.

The approximately 9.5 million surviving veterans of WWII of 16.5 million who served, represent around 36 percent of all living veterans. Currently there are more than 5.8 million veterans who are over 65 years of age. By the year 2000, the number will be almost 9 million.

Along with advancing age comes an increased prevalance of chronic diseases and disabilities which translate into an increased need for health care resources. Available information relates that health care experts estimate 80 percent of those who are 65 years of age and older have incurred at least one chronic disease, and there is a 50 percent chance that a person over 75 years of age will be inflicted with five or more conditions, either acute or chronic. Therefore it is obvious that aging veterans will require additional VA health care resources as the size of that population increases.

One of the major problems that confronts VA as well as the entire nation is the growing need for nursing home care units designed to provide different levels of care. Because of some misguided information provided by the Grace Commission and others unfamiliar with the VA medical care system, there has been an effort to discontinue the construction of VA nursing home units on the grounds they are too costly in comparison with the cost of construction of similar units in the private sector. This is a good example of the fallacy of much of the rationale developed by those bent on privatization of the VA health care system, stemming mainly from a fundamental lack of understanding of the mission of the program.

There is no doubt that VA-constructed units have been costly, and we are supportive of the efforts at cost control. However, it is also true that the patients found in the VA nursing home units many times are more severely disabled and require more intensive care and thus more sophisticated facilities than can be found in many private sector nursing homes. The minimal care provided in many private sector units is simply unacceptable in a VA unit. The Department of Veterans Affairs cannot escape this responsibility nor do we believe Congress would allow it to do so. There is a serious need for VA to be authorized and funded to develop nursing home units where the need for them is apparent.

It is particularly important to closely monitor what is happening with respect to Alzheimer's Disease, and the treatment and research of those who suffer its consequences. This problem is so important that every VA medical center should have a program to work with both patients and their families, as is done in the hospice

movement.

Speaking of the hospice movement, the Veterans Administration should continue to expand this program. It does a tremendous amount of good for both the patients and their loved ones.

The American Legion feels that every VA medical center should have a Geriatric Evaluation Unit. This enables the staff to identify problems relating to the aging veteran patient and to work out a treatment program for them.

There are currently 10 Geriatric Research, Education and Clinical Centers (GRECCs) in operation in the medical care system, although 15 others have been authorized but not funded. These units provide one setting for integrated programs of research, educational and specialized clinical activity relevant to problems of the aging. Important research on Alzheimer's and other problems is being carried out through the GRECCs. More emphasis needs to be placed on establishing additional units, so that VA may maintain a leadership role in geriatric health care, health services research and specialized geriatric medical education.

It is a foregone conclusion that the aging phenomenon will continue, so that the need for programs for aged and aging veterans will confront the nation for the foreseeable future. Those who are poor become the responsibility of the Government, and those who are veterans have a right to look to the Department of Veterans Affairs.

In setting out The American Legion's views of the parameters of VA responsibility and capability to care for aging veterans, we mention the fact that we are discussing the problems of the poorest element of the veteran population. Most veterans have never been in a VA hospital and the majority never will. We are discussing here those who have service-connected disabilities, or who would have to look to the Government for assistance in any case because they cannot afford the cost of care.

It must also be stated that the services for the aging veteran population, along with other programs carried out in the medical care system, are in danger of being reduced or deleted as the result of funding shortages. The fact that the budget for the VA medical care program has been decremental over the past several years has now forced the closure of beds, curtailment of certain treatment programs, elimination of treatment of many nonservice-connected veterans, excessive waiting times for admission and the closing of clinics. Contracts with community nursing homes are being reduced from six months to ninety days and less. The list goes on and on.

The government must provide adequate and necessary funding to maintain the

programs of the VA medical care system, provide adequate compensation levels to attract and retain the highest quality professional staff, and ensure funding for renovation and replacement of aging and inadequate facilities.

We have come to what amounts to a crossroads, and a great deal of serious thought and deliberation must be given as to whether decremental funding of the Veterans Health Services and Research Administration will be continued, leading to further erosion of the care and services provided; or whether adequate funding will be provided to maintain a medical care program for veterans at the level of quality needed for it to continue as the finest and most comprehensive medical care program to be found anywhere in the world.

The American Legion feels that a strong and genuine commitment needs to be made to the latter, as America's veterans deserve no less.

Mr. Chairman, that concludes our statement.

STATEMENT OF

ALVAR SVANBORG
Professor of Medicine; Chief, Geriatric Medicine Section;
Clinical Director of Research, Gerontology Center;
University of Illinois at Chicago

And

HOWARD L. STONE, ESQ.
Chief Counsel to the Department of Illinois AMVETS

Accompanied By

NOEL C. WOOSLEY
AMVETS National Service Director

Mr. Chairman, members of the Committee, AMVETS is pleased to have this opportunity to present a pilot project for geriatric reactivation of elderly veterans that could revolutionize the health care service needs of the aging veteran population.

The AMVET Department of Illinois in cooperation with the University of Illinois at Chicago's Department of Medicine, plan to open the first nursing home dedicated to teaching and geriatric reactivation of elderly veterans. In reviewing your letter of invitation, it is apparent that this Committee is eager to review and make recommendations on a broad scope of issues facing the aging veteran as well as the aging population as a whole. AMVETS has therefore elected to share with this Committee a truly unique alternative in the realm of long term care.

For the purpose of today's written testimony we are including an Executive Summary of the Illinois AMVETS Teaching Nursing Home Pilot Project.

ILLINOIS AMVETS TEACHING NURSING HOME

A Pilot Project For Geriatric Reactivation of Elderly Veterans

EXECUTIVE SUMMARY

Almost everyone, in growing older, is beset with fears and concerns about losing previous capabilities, becoming chronically disabled, and facing a diminishing quality of life. Such fears can be relieved and such outcomes prevented or minimized through a comprehensive reactivation philosophy.

An aging person who is fortunate enough to be spared chronic disabling diseases should continue to have sufficient functional capacity to carry out all ordinary living activities to very advanced ages. Unfortunately, most older persons acquire diseases and disabilities and have complex problems of a physical, psychological, and social nature that call for specific efforts at treatment and restoration or maintenance of function.

The Illinois AMVETS Teaching Nursing Home will address these problems in serving elderly veterans of the VA Medical District 17 and from elsewhere in the Great Lakes Region.

Aging and Illness
The broad longitudinal population study of 70-year-old people in Gotenborg, Sweden, begun under the leadership of Dr. Alvar Svanborg in 1971 and still continuing, has contributed greatly to the knowledge of the normal aging processes, and the social and medical conditions of the population to obtain basic data for planning the care of the elderly, and, to evaluate the possibility for preventive actions. Among its conclusions were these findings:

> Age-related declines in many functions occur later in life than was usually believed.
>
> In healthy individuals, decline in psychological functioning occurs rather late in life, if ever. Even in the 8th decade, the majority of healthy individuals have well preserved mental abilities. Rapid changes are usually signs of physical or mental diseases.
>
> It is still possible to regain functional capacity and performance in the elderly, even in their 80's, by systematic training and rehabilitation.
>
> Adjustment and life satisfaction are not necessarily related to age per se, but to health and environmental factors.

Other longitudinal studies conducted in the U.S. add weight to the general scientific impression that health status, not age per se, is the most important determinant of whether one will experience some fall-off in intelligence and function.

On the otherhand illness becomes more prevalent and complex in elderly persons. Presence of 4 or 5 simultaneous illness conditions is not uncommon in elderly persons. Common problems occurring simultaneously are; coronary heart disease and congestive heart failure, cerebrovascular disease, dementia syndrome, degenerative joint diseases, hearing and vision impairment, tumors, gait disorders, and diabetes mellitus.

Nonspecific problems are prevalent such as pain, refusal to eat and drink, falling, incontinence, confusion, sleep disturbance, depression, drug intoxication, etc. Some suffer from nonspecific fatigue.

Dementia and Health

How much of senile behavior --loss of memory, loss of orientation, confusion, inability to calculate or reason--is the result of the situation into which we thrust the elderly? How much is attributable to somatic disorders? Their exists substantial scientific evidence showing long-standing cultural misunderstandings of aging. Needless institutionalizations, inadequate and incorrect medical diagnosis, and self-imposed mental and physical deterioration are not unusual.

In general, old age is a time of slower responsiveness and slower recall, but most of the elderly learn to compensate for that slowness. Senility is not inevitable with age, but is associated with physical debilitation that often accompanies age. Because mental impairment can mask more than 100 different physical and emotional problems in older patients, the symptoms of "senility" should be treated as a medical emergency necessitating comprehensive and sensitive medical diagnosis and care.

Care Programs

Clinical diagnosis and complaints associated with the normal aging do not by themselves indicate a patient's functional capacity nor their capacity to achieve a viable living status. Elderly persons lose reserve capacity with age such that a mild illness may produce a more severe deficit in functional capacity. It takes an older person longer to recover from a similar illness than it does a young person. The reactivation of frail elderly in general, and especially in those with multiple disease, usually imply considerable risk for overloading, and therefore has to be dealt with by interdisciplinary teams with a guarantee of adequate medical expertise and experience.

In working with older people the overall goals may differ from those of younger patients but the basic concept remains the same - to achieve and maintain the maximum level of functional ability possible. The aim of reactivation is generally defined as restoration to an achievable level of independent function, or to maintain or maximize remaining function to help the elderly continue to live as full a life as possible.

For elderly veterans exhibiting early signs of senility, a dementia assessment program will assess their capacity, identifying psuedodementias, extent of defects, and the influence of disease on function.

Changing Demographics

We are fast becoming a nation of old people. The 75+ age group, the so-called "old-old" in whom physical problems of age become more common, is the fastest growing. It increased by 32% between 1970 and 1980, almost 4 times the rate of growth of the rest of the population. The growth rate of the "oldest-old", americans over 85 is especially rapid, having grown almost 60% between 1970 and 1980. By the year 2000 there will be as many as 35 million elderly americans, half of them over age 75.

Expansion of the elderly veteran population is impacting the Veterans Administration sooner than expansion of the total elderly population is impacting society in general. This is due to the large number of WWII and Korean veterans reaching senior citizen status. By the year 2000 nearly two out of every three men over age 65 will be a veteran. The impact of the expanding elderly veteran population is at hand and will increase markedly each succeeding year.

Over the next two decades, there will be a major change in the age structure of the veteran population, and the VA will have to address the reality of rapidly increasing demands on their health care system. With the assumption that there are no further wars in this century, the total number of veterans will decline, but the average age will dramatically increase. Seventy-five percent of the 11.1 million veterans who served in World War Two will reach age 65 by 1990. The actual number of all veterans aged 65 plus will more than double between 1985 and 1995. By the year 2000, there will be 9 million veterans aged 65 plus. This number will constitute 37 percent of the veteran population. And, by the year 2015, 45 percent of the veteran population will be aged 65 plus. Further, between 1980 and 2000 a 136 percent increase in the number of veterans age 85 plus is projected.

The Project

The Illinois AMVETS Service Foundation, in partnership with the University of Illinois, and Veterans Administration Medical District 17 institutions, proposes to construct and operate a special geriatric care facility providing programs which emphasize reactivation of dependent elderly veterans. The AMVETS will construct, own, and operate the Teaching Nursing Home; the University of Illinois will provide the building site, academic programs, and program experience; and the Veterans Administration will be the source of the majority of dependent elderly veterans and will provide their cost of care, reimbursing the Teaching Nursing Home as a preferred placement contract nursing home.

The capital program will provide a facility for 130 residents veterans containing special facilities for reactivation, family training, education, and environmental design features planned to complete the care programs. The building size, and capital cost is estimated at 88,000 gross square feet and $8.8 million.

The objectives of the Teaching Nursing Home (TNH) are to fill the existing gap in our national health care system between acute hospital stays and long-term institutionalization by providing an alternative lower-cost setting dedicated to reactivating elderly veterans to independent status; reduce the number of veterans requiring hospitalization or long-term institutionalization by improving their functioning and training family caregivers; increasing the level of functioning of veterans needing long-term care thereby reducing the amount of service they require; and expanding early detection, assessment, diagnosis, and treatment planning of dementing-like illnesses and conditions.

This project will facilitate systematic long-term research and development in medical, functional, and psychosocial care programs; financial benefit analysis of reactivating dependent elderly veterans; demonstrating health care service models designed to provide cost effective care by avoiding institutionalization; and provide for transfer of research and demonstration results to VA care systems and future health care providers through teaching and training programs.

Education and Training

University of Illinois education and training programs and VA inservice training programs will benefit uniquely from the TNH project by participating in the planning and implementation of care services, staffing and facilities design. The product will be a clinical setting integrating care services, teaching and research in a way not available in any nursing home setting. The Colleges of Medicine, Nursing, Associated Health Professions, Pharmacy, Social Work, Dentistry, and Health, Physical Education and Recreation have been identified as direct participants. The School of Public Health, and the Colleges of Art, Architecture

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and Urban Planning, and Business Administration will have roles relevant to their specializations in health services research, environmental design, and management.

Research

Research will assume a primary role in the Teaching Nursing Home. There are many important areas of research: The nature of drug metabolism; the nature of nursing in nursing homes; formulating care plans; relationships between privacy and social interaction; the physical environment and design elements; and resident stimulation. The participating academic units will find fertile areas for research in such areas as nutrition, behavior, caregiving, team development, and social services. Medical research may involve investigations in cardiovascular status; pulmonary function and disease; clinical pharmacology, pharmacokinetics, and drug sensitivity; psychological and psychiatric factors in reactivation; sexuality in aging; functional assessment of the elderly; communication disorders; cardiac disorders; and a variety of special conditions relevant to aging and care of the elderly.

The cost of health care for the aged will rise due to increasing numbers of elderly veterans and the higher per capita cost of providing health care for the aged. Priority consideration will be given to implementing research programs investigating the care and cost effectiveness of programs provided by the TNH, as compared to alternative care programs.

The Pilot Project Grant

The care programs result in care costs which exceed current contract nursing home costs in District 17. A special pilot project grant is requested to supplement contract nursing home costs currently provided in the District's institutional budgets. The annual cost of operating and maintaining the Teaching Nursing Home has been estimated at $7.28 million per year based on 1988-89 costs, resulting in a per diem cost of $170. Expenses are a function of fixed costs and variable costs. Fixed costs include mortgage, insurance, utilities, maintenance, management, and other non-program expenses. Variable costs are wages, salaries, supplies, and professional services required for programs conducted in the facility.

The Pilot Project Grant amount is calculated as:

TNH per diem cost	$170
District 17 per diem participation	$100
Grant per diem cost	$ 70

A 5-year agreement is requested, with a 5-year renewal option. The estimated 5-year costs, including a 4% annual escalation rate are:

Year 1	$2,657,000
Year 2	$2,763,500
Year 3	$2,874,000
Year 4	$2,989,000
Year 5	$3,108,500
Total - 5 years	$14,392,000

Submitted by: ILLINOIS AMVETS HEALTH CARE FACILITIES CORPORATION
in partnership with the University of Illinois and
Office of the Director, VA Medical District 17,
April 13, 1989

STATEMENT OF MR. HOWARD L. STONE
CHIEF COUNSEL TO THE DEPARTMENT OF ILLINOIS AMVETS

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want to thank you for giving me the privilege and honor to appear before you.

Before I start, I must give you my background as it concerns the elderly. For the past 12 years, I have represented the owners of nursing homes, been involved with governmental agencies, litigated against government agencies and have an academic position as a lecturer at the School of Public Health at the University of Illinois in the area of long term care. I believe, because of my professional background, that I bring an unique insight into the area of long term care. I have served in the federal government as a revenue agent with the Internal Revenue Service for nine years, and as a prosecuting attorney for approximately four years with the United States Department of Justice for the Northern District of Illinois. This fact-finding experience has allowed me to gain invaluable insight into the needs of our elderly at the present time and in the future.

I do represent the Amvets in their quest to build a reactivation center which will send veterans to their homes or communities, rather than to nursing homes. However, we will only be able to pursue this program with additional funding over the per diem rate from the Veterans Administration. This, insofar as we know, is the first facility of its type in the country which will follow a Swedish model of reactivation. The Amvets are the first

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and its professionals for their tireless efforts on this project, in particular Dr. Winship, Dr. Kelly, Paul Stanford of the West Side Veterans Administration, John Fears of Hines VA in Maywood. These individuals literally turned heaven on earth in order to allow us to plan this project.

At this time, I would like to introduce to you Dr. Alvar Svanborg. Thank you for giving me the opportunity to appear before you.

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

ISSUES RELATED TO OLDER VETERANS

WASHINGTON, D. C. APRIL 13, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the entire membership of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I wish to sincerely thank you for having asked me to speak here today to present our perspective on the enormous challenge facing this nation in properly caring for its elderly veteran population.

At present, it is estimated that the number of Americans aged 65 and over is growing at twice the rate of the general population and currently makes up over 12 percent of our population. By the year 2000, there will be almost 35 million persons over 65 and nearly five million over 85. As the number of elderly continues to grow, meeting their long-term health needs presents a profound challenge to our present system.

The elderly now use a full 40 percent of the nation's hospital and doctor care. They take a third of the prescription drugs that the nation produces and almost half of the over-the-counter medicines.

Yet this nation's health care system is not yet properly prepared to deal with their complicated and interacting ailments and drastically changed ways of life. Nor are the mechanisms in place for properly caring for their other social and financial needs.

Of course, of fundamental concern to the Veterans of Foreign Wars is the proper provision of care--first and foremost health care--to this nation's rapidly aging veteran population. And, of course, the primary vehicle for providing the nation's aging veterans with the full continuum of care that they have earned in the service of their nation is the DVA's Department of Medicine and Surgery. It should be emphasized that our veteran population is aging much more rapidly than the population as a whole. Since the DVA's Department of Medicine and Surgery is this nation's largest integrated health care system, the skill, dedication and compassion with which it executes its legal and moral mandate, "to care for him who shall have borne the battle," will indeed directly and indirectly impact this nation's entire health care delivery network.

The DVA health care system is now being called upon to properly answer its greatest challenge--caring for the very rapidly aging veteran population. As I have already mentioned, although the entire American population is advancing in years, on the average, the pace is much more rapid among veterans. By the year 1990, veterans over 65 will make up more than a quarter of the veteran population and by the year 2000, this number will be over one-third. This escalation will continue up until 2010 and, at that time, we can expect those veterans over 65 to number more than 12 million.

In view of the health problems associated with advancing years, the DVA's medical program now, and in the future, must be prepared for increased, diversified and a more costly demand for services. The United States Congress must also be prepared to address this challenge and provide adequate funding to allow the DVA to meet its mandated responsibility.

While there are a vast array of numbers available to support this challenge, let me mention just a few to place the immensity of what lies ahead in perspective. Of all individuals since the Birth of Christ who ever lived beyond 65, one-half of them are alive today: by the year 2000, two-thirds of all American males over 65 will be veterans and these veterans will be eligible for DVA health care. According to the DVA, by the year 2000, 115,000 veterans a day will use its extended care programs as compared to 40,000 in 1985. Seven hundred sixty thousand veterans will require non-institutional long-term care, up from around 15,000 today. By then the DVA must also be able to provide for as many as 33 million outpatient visits, as compared to 18 million in 1985. With acute care discharges increasing up to 54,000 more than today and the continuing cutbacks in Medicare and Medicaid, which are the sole medical insurances of approximately 41 percent of our veterans, these estimates are probably very conservative. According to a Lou Harris Poll, 60 percent of all veterans surveyed said they would use DVA health care if they were eligible and if the facilities were readily available. It is therefore quite clear that if the DVA does not acknowledge and respond to this challenge in a well-thought out and executed manner, and if the DVA is not properly funded by the Congress and the Administration, the entire health care system may be overwhelmed.

The Department of Veterans Affairs' ability to properly fulfill its stated mission "to ensure quality medical care is provided on a timely basis to eligible veterans" is now in very serious jeopardy. The DVA health care budget is strained to the absolute limit and it is now evident that the DVA is facing its most severe financial crisis in many years.

At the very heart of the problem: Not enough money. Even though federal funding for veteran's health care has nearly doubled since 1980 to $10.4 billion in FY 1989, after inflation is taken into account, there has been practically no gain whatsoever. During this period, the Department of Veterans Affairs health care system has been treating more patients than ever before.

In fact, while other federal budgets are increased, DVA budgets are falling behind inflation. Since 1985, Medicaid spending has grown by 55 percent and Medicare spending is up to 32 percent. Spending for veteran's health care, on the other hand, has increased by only 17 percent over the same period. Since 1980 DVA patient workloads have increased substantially--the number of hospital patients is up seven percent, outpatient visits have increased by 29 percent, veterans receiving DVA paid nursing home care is up 63 percent, however, the DVA's medical budget has been increased by only $400 million in real dollars during this period.

The Reagan Administration budget for the DVA in FY 1990 would have cut nearly 9,000 DVA health care employees, reduced medical facility construction and denied medical care to thousands of veterans. The DVA health care system has already begun terminating health care programs, taking hospital beds out of service (in addition to the thousands of surreptitiously closed "phantom beds") and to deny health care to category B and C veterans at virtually every DVA hospital in the country.

Substantiating the VFW's analysis of the severity of the problems facing the DVA health care system, Veterans' Affairs Committee and DVA officials themselves are now predicting that the DVA medical funding shortfall will reach $1 to $1.5 billion FY 1990, unless Congress provides supplemental money.

This rapidly escalating health care tragedy for veterans is now being felt at virtually each and every one of the DVA's 172 hospitals. Throughout the system, services are being terminated, the replacement of vital equipment is inadequate and in some cases almost nonexistent; critically needed construction, renovation and repair are being curtailed, medical supplies are in increasingly short supply and more and more veterans are being turned away from needed medical treatment.

It now bears mentioning that Secretary of Veterans Affairs, Edward J. Derwinski, has appealed to the White House Office of Management and Budget for a supplemental appropriation of $314 million and 1,539 in full-time employees for the current fiscal year and an amendment to FY 1990 administration proposal that would provide an additional $512 million and 5,090 medical employees. Secretary Derwinski is also seeking an additional $84 million for major medical facility construction.

The VFW would point out that this FY 1989 supple emtal request, even though greatly appreciated is, in fact, well below what is needed to meet the over $600 million shortfall in the current veteran's health care budget. The requested supplemental appropriation of $314 million would only accommodate the mandatory spending called for under Public Law 100-322. In any case, it is absolutely clear that the supplemental request is vital to sustaining the operation of the DVA's health care system. There is no more fat to be cut, nor time to be wasted.

The Department of Veterans Affairs has been in the forefront in vertically integrated health care delivery systems and this role should be enhanced through making adjustments to the system in response to the needs of veterans as they evolve. In particular the Department of Veterans Affairs medical system must quickly convert excess hospital capacity to meet nursing home care as well as other extended care and ambulatory care needs. In concurrence with the veterans service organizations' Independent Budget for the DVA of which we are a subscriber, we recommend that the DVA increase its nursing home bed census by approximately 3,000. We also recommend that Community Residential Care (CRC) programs be established at each DVA medical center. These programs represent an inexpensive and humane means to care for veterans who do not require hospital or nursing home care but, because of medical or psychological conditions, are not able to live independently. We would also ask that geriatric evaluation units (GEUs) be established at each medical center. GEUs provide comprehensive, medical, functional, psychological and envirnomental assessment to improve treatment and discharge planning for elderly patients who typically have multiple medical problems.

The final recommendation that we will make at today's hearing is that the number of Geriatric Research Education, and Clinical Centers (GRECCs) be increase from 10 to 15. GRECCs are centers of excellence designed for the advancement and integration of geriatric and gerontological research, education, and clinical achievements into the total DVA health care system. An expanded GRECC program will allow the DVA to maintain its clinical and educational leadership role in dealing with the problems of aging. It will foster the development of new approaches to care that meet in turn goals of improvement in care and cost containment. The timetable with respect to GRECCs has slipped, and our current goal is to have 25 GRECCs, the maximum number currently authorized by statute, by 1995. This will come close to having a GRECC in every one of the DVA's medical districts.

Mr. Chairman, I would once again sincerely thank you and the other members of this Subcommittee for conducting today's very important hearing and inviting our participation in this undertaking. The VFW is pleased and proud to be of assistance in formulating a strategy for caring for this nation's deserving elderly veteran population. Thank you. I will be happy to respond to any questions you may have.

THE RETIRED OFFICERS ASSOCIATION

201 North Washington Street
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STATEMENT OF

THE RETIRED OFFICERS ASSOCIATION

before the

HOUSE COMMITTEE ON VETERAN'S AFFAIRS

Subcommittee on Oversight and Investigations

Presented by

Commander John F. Wanamaker, USN, Retired
Deputy Director of Legislative Affairs
The Retired Officers Association (TROA)

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Commander John Wanamaker, USN Retired, Deputy of Legislative Affairs for The Retired Officers Association (TROA) which has its national headquarters at 201 North Washington Street, Alexandria, VA. Our association has a membership of more than 360,000 active duty, retired and reserve officers of the seven uniformed services. Included in our membership are approximately 50,000 auxiliary members who are survivors of former members.

The members of The Retired Officers Association wish to thank the chairman and members for holding these timely hearings. There currently exists a situation whereby many older veterans are being subjected to out-of-pocket costs for their health care exceeding that required by non-veterans of the same age bracket. I specifically refer to those veterans in category "C", over age 65, and eligible for Medicare.

Mr. Chairman, part of the dilemma faced by aging veterans is the inconsistency of two federal statutes. (P.L. 99-272 Veterans Health Care Amendments of 1986 and P.L. 100-360 Medicare Catastrophic Coverage Act of 1988.) These conflicting laws would be further exasperated should the administrations' legislative proposals to establish a "user fee" tax on certain veterans who seek medical care at VA medical facilities. These user taxes would require many aged veterans to pay $5-$10 per outpatient visit, $3-$5 per outpatient prescriptions and a $9 per-diem tax for inpatient treatments.

P.L. 99-272, which became effective on July 1, 1986, was a dramatic reduction in the health care provided older (over age 65) veterans who before that date were provided care in VA facilities regardless of income. After that date, veterans in Category "C" (incomes above $20,000 if single, $25,000 if married) are required to pay a deductible for their health care provided by the VA. By establishing a Category "C" status, it then became a device for VA facilities to refuse care when reduced staffing and availability of facilities were attributed to budget restraints. In fact, many facilities wrote their patients of long standing that their facilities would no longer be available to Category "C" veterans. With continued budget uncertainties for VA health care and no assurances that there will be any continuity to their care veterans over age 65 in Category "C" are changing their providers to the private sector. In most cases they are eligible for the Medicare program. The scary situation occasionally surfaces whereby an aged veteran accustomed to receiving care at VA or in some instances military treatment facilities, now find that care no longer available and because of that availability for so many years they did not enroll in Medicare Part "B". They then suffer a significant financial penalty for late enrollment.

A veteran in Category "C" is also required by P.L. 99-272 to pay the cost of care or Medicare deductible for the first 90 days stay plus one-half the deductible for each additional 90 day stay. P.L. 100-360, establishes a catastrophic cost cap, beginning on January 1, 1989, for health care provided Medicare beneficiaries. That law limits the deductible to a single deductible for each 365 day period. A veteran in Category "C" who may be admitted to a VA hospital (paying the required VA deductible) and could be turned away on future visits (this is becoming more frequent) and would then be required to rely on Medicare where he would start all over again and pay another deductible. This type of situation causes the aged veteran to be subjected to higher charges than other citizens his own age group who are not veterans. In fact, he could be trapped into higher total medical costs by seeking care at a VA facility. The current administrations' proposals to establish a "user tax" would add to this additional out-of-pocket cost to the aged veteran. This is the problem that this committee must resolve. There must be a cross transfer of credits of VA deductible toward Medicare or vice versa. At least the deductible for Category B and C patients over age 65 should be limited to a single annual deductible for hospitalization. Other alternatives to correct this problem are:

1) Eliminate the means test for Category "C" patients over age 65, or

2) Require Medicare be subject to reimbursement to the VA for care provided Medicare eligible beneficiaries, or

3) Exchange deductible credits between VA and Medicare to limit the costs to beneficiaries to the limits established by P.L. 100-360.

Our association would recommend the second of the solutions above. Testimony provided by VA witnesses have indicated that the VA can provide health care at less cost than the private sector. The current various programs work in such a way that Medicare is receiving a "free-ride" for all the care provided by the VA for Medicare eligible beneficiaries. A point that should not be overlooked is that the majority of the veterans in Category "C" are also subjected to the income surtax imposed by the P.L. 100-360. In other words, those veterans over age 65 who utilize a combination of VA and Medicare facilities are not only paying more than their non-veteran counterparts through multiple deductibles but are also paying an income surtax which pays for the costs for 60 percent of those beneficiaries from P.L. 100-360 who pay no tax at all.

It may seem to the members of this committee that those who meet the means-test should pay for the others, however, our association membership who are veterans, in many cases of three wars, now find that they are required to pay for the health care for those who didn't serve. Our members who were promised that by serving 20 or more years in the military they would receive lifetime health care for themselves and their dependents. Not only has the health care provided by military treatment facilities for retirees and their dependents been significantly reduced, but the VA care costs more than Medicare and now we're being asked to pay for the care for the majority of the others.

Mr. Chairman, since these oversight hearings are general in nature, I feel it only proper that I raise the issue of the VA's commitment to the National Disaster Medical Plan. We have heard recent reports that thousands of VA hospital beds are turned over unused because of shortages in staff. Also, the high costs of

medical care in general reflects a shortage of providers. The Senate Armed Services Committee reported that the Naval Reserve medical capability to be a "warstopper" and that military medical facilities are operating at partial capacity due to funding and staff shortages. All these reports make one come to the conclusion that there must be stress in our ability to meet the National Disaster Medical System requirements. The Committee must answer the question, is the VA medically ready to handle a sudden national disaster, be it war or nuclear or biological catastrophy? Since the VA medical system shares in that plan, are we meeting the requirements expected of us? I have been told that the VA has the requirement to provide 25% of their available facilities immediately on the notice of a national disaster with a continuous phased plan to provide a minimum of 25% of facilities over time. With such a commitment and more hospital beds being converted to nursing facilities, how will the VA react? Will casualties push out nursing home patients? Is such a plan realistic? These issues require an in-depth investigation to determine the overall adequacy of the National Disaster Medical Plan to meet its intended objectives.

Mr. Chairman, currently working its way through the Congress is a supplemental appropriations request for about 300 million dollars. This committee has agreed that amount is inadequate and has added funding which is considered absolutely essential, still leaving a shortfall which will result in additional staff shortages and turning over more beds. This will effect the Category "C" veteran patients that are already in the situation I am speaking of.

Last Thursday, it was reported that Secretary Derwinski, the newly appointed VA secretary, was exploring the possibility of using certain DoD medical facilities to meet the VA shortfall. This would cause one to laugh if the situation wasn't so serious. For years now the DoD medical population has been unable to receive care at DoD medical facilities for the same reasons that they are denied care at VA facilities - lack of staff and availability of space. That proposal will not solve the problem. That is like asking one sick patient to take care of the other. Both the VA and DoD facilities need help. By this, Mr. Chairman, I don't want

to convey that I would oppose joint VA and DoD efforts to solve their medical problems. There are excellent examples where such joint efforts are already working well. Examples such as the Albuquerque N.M. and the proposed Nellis (Las Vegas) hospital should resolve that areas joint needs. The only thing that these joint efforts illustrate is that it takes money to build new facilities. We already know the present system is turning away Category "C" patients because of these shortages.

The solution is long term and include 1) training of medical professionals from the ground-up with obligations to provide service upon graduation 2) expand the physical capability (use that which is turned over and not utilized) with modern equipment and 3) Competitive pay with the private sector. If these steps aren't taken, the physical structure will continue to deteriorate and the staffing will abandon the outmoded system for the private sector where the financial and workplace environment is more rewarding. Only money can provide these needed measures and the administration and the Congress must realize what it takes.

Mr. Chairman, since there is so much uncertainty surrounding health care for the aged veteran, it might be better if the Congress came right out and either provided the care as an entitlement or deny such care exists. This uncertainty of availability can contribute to the patient's anxiety and of their families. It would be better to know before spending time and money only to find out there is no health care in the VA system for the older Category "C" veterans.

In summary, our association would recommend that the Medicare program be required to reimburse the VA health care system for care provided to Medicare eligible beneficiaries or eliminate the VA means-test altogether for these veterans. If that can not be done, than require interagency exchange of deductible data to prevent the veterans from being charged more than the non-veterans. Finally, continue to seek coordination of services between DoD and VA, however, recognize that both systems are currently unable to provide the level of care to all of their own eligible beneficiaries.

Thank you Mr. Chairman, I will try to answer any questions the members may have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
April 13, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans and its Ladies' Auxiliary, I want you to know how very much we appreciate the opportunity to appear here today and share our views relating to the various issues facing the Department of Veterans Affairs (DVA) with respect to providing health care and other services to America's older veterans.

Mr. Chairman, VA is today faced with many challenges of varying degrees in the arena of providing health care services to this nation's entitled veterans. None, however, may be as great and as immediate as is presented by aging veterans.

The issue, in our view, is the VA's capacity to treat the large influx of World War II and Korean War Veterans, whose need for both acute and long-term care will peak as the century nears its end.

The demographic pattern of the veteran population appears key to assessing the future needs of the VA health care system. Of the 27.3 million living veterans, an estimated 9.4 million (34%) served in World War II and another 4 million (15%) in Korea. This means that by the year 1990, one out of every four veterans will be 65 years of age or older; by the year 2000 one out of three will be in that age group.

Although many of these veterans will require acute care, many more will need skilled nursing care, especially as life expectancy increases. VA's own projections show, that in 1990 there will be about 1.4 million veterans 75 years of age and older; in 2000, the number reaches 3.8 million.

It is estimated that some 5000 VA hospital beds are now occupied by veterans who belong more appropriately in a nursing home care bed. However, the VA itself does not have sufficient nursing home care beds and, for various reasons, are unable to place these veterans in community nursing homes.

The fact that there is nowhere to place these 5000 veteran patients underscores the dilemma the VA will be confronted with in the near future.

Currently, the VA supports some 30,000 nursing home care beds -- about 30% in VA owned and operated nursing home care units and the remainder in either state veterans homes or under contract in some 3000 private nursing home facilities in the community. It is estimated by the year 2000 the number of beds will have to double, to 60,000, in order to keep up with anticipated demand. Unfortunately, we have seen no indication that such an expansion will occur.

Mr. Chairman, a formula has been devised that provides 30% of all nursing home patients be treated in VA owned and operated facilities, 40% treated in state veterans homes and the remaining 30% of VA supported patients be treated in community

beds. The fact that nursing home construction in the private sector has virtually come to a halt raises serious concerns, in our minds, as to the capability of the VA to continually place veterans in non-VA owned and operated nursing home care beds.

The VA's Five Year Developement Plan (1989-1993) contains no new nursing home bed construction projects. Rather, that document stipulates the implementation of a long-term care policy that would shift the provision of additional nursing home care beds away from new VA owned nursing homes toward community and state alternatives, as well as the conversion of existing VA hospital beds to nursing home care beds.

In view of the apparent moratorium in the private sector of nursing home construction and the VA's seeming inability to convert a significant number of acute care beds to long-term care beds our concerns are heightened regarding the VA's ability to provide needed long-term care to entitled veterans.

Mr. Chairman, as in other areas of health care, the VA should be proud of their efforts in providing care to the elderly. One such exemplary example is the establishment of Geriatric Research Education and Clinical Centers (GRECCs) representing a system wide network of centers of excellence.

In addition to the ongoing efforts of the ten GRECCs the VA is able to provide for veterans long-term care needs via a variety of other methods such as:

VA Domiciliaries
Hospital Based Home Care
Adult Day Health Care
Geriatric Evaluation Units
Respite Care
Hospice Care
Community Residential Program

Without question, Mr. Chairman, these types of non-institutionalized care programs are beneficial towards meeting the health care needs of disabled veterans and serve as a convenient and cost effective method of providing such care.

In order to deal with the ever increasing needs and in consideration of budget constraints we feel it wise to concentrate efforts toward a rapid and substantial expansion of these non-institutional health care programs. These may be provided less costly and have the added advantage of allowing veterans to retain their independence and the opportunity of residing with their families in the community.

In our view, the VA has long over-emphasized the provision of acute medical care while under-emphasizing the need and provision of long-term care. This trend should be reversed immediately.

Mr. Chairman, in recognition of the needs of older veterans, the DAV Department of California and Sepulveda, California, VAMC have entered into a joint pilot program, the Home Assessment Program for Successful Aging. Launched in July 1988, this program is designed to utilize DAV volunteers -- after receiving specialized training by the GRECC staff -- to visit elderly veterans in their homes.

A structured interview will obtain a comprehensive picture of the veterans physical and mental health, diet, social habits, physical disabilities and details about the living area. The major goal of the program is prevention and early detection of diseases or disabilities in older veterans, as well as the elimination of health hazards in the home.

Although formal evaluation of the program is not yet possible due to the short time it has been in existence, preliminary data suggests it will yield very positive results toward keeping veterans in their homes instead of requiring hospital admission. (I have appended to my statement information regarding the program, as well as an article from the February 1989 edition of DAV Magazine).

Mr. Chairman, the most recent example of the crisis facing the VA in the provision of long-term care -- indeed health care in general -- has occurred at the Syracuse, New York, VAMC.

We have been furnished information that the Syracuse Nursing Home Care Unit -- 50 beds -- has been closed due to the budget shortfall and reopening is unlikely to occur prior to 1991.

Incredibly, it is being proposed, by VAMC management, that the nursing home care unit -- currently unavailable to disabled veterans -- be rented to a private nursing home concern or the county as a solution to the long-term care bed crisis in the community.

Mr. Chairman, it appears that after years of chipping away at the VA health care system a large block of granite has been dislodged. It is ironic that many outspoken critics of the VA have, for years, called for the dismantling of the VA for the purpose of attracting VA patients into the private medical community, which has overbuilt and become saturated with a surplus of unfilled acute care beds only to see the VA reverse the situation by offering their beds to the private sector which apparently has a shortage of long-term care beds.

The prospect of the VA literally discharging disabled veterans out of VA nursing care home care beds simply to satisfy the needs of the private sector is incredulous. If the VA is now selling/renting their interests in nursing home care what will they attempt to divest themselves of next, orthopedics, post traumatic stress disorder, vets centers, prosthetic services?

In conclusion, Mr. Chairman, we would offer the following recommendations which we view as necessary simply to maintain the VAs ability to continue to provide needed services to aging veterans:

1. A dedicated and meaningful program to convert, where possible, unused or under-utilized acute care beds to long-term care beds.

2. Expansion of non-institutional health care programs.

3. Immediate expansion, to 15, the number of GRECCs with a goal of having 25 operational by fiscal year 1995.

4. Establish Geriatric Evaluation Units at each VA medical center.

5. Increase the nursing home care average daily census (rather than the proposed reduction of nearly 8,000 veterans treated in Fiscal Year 1990).

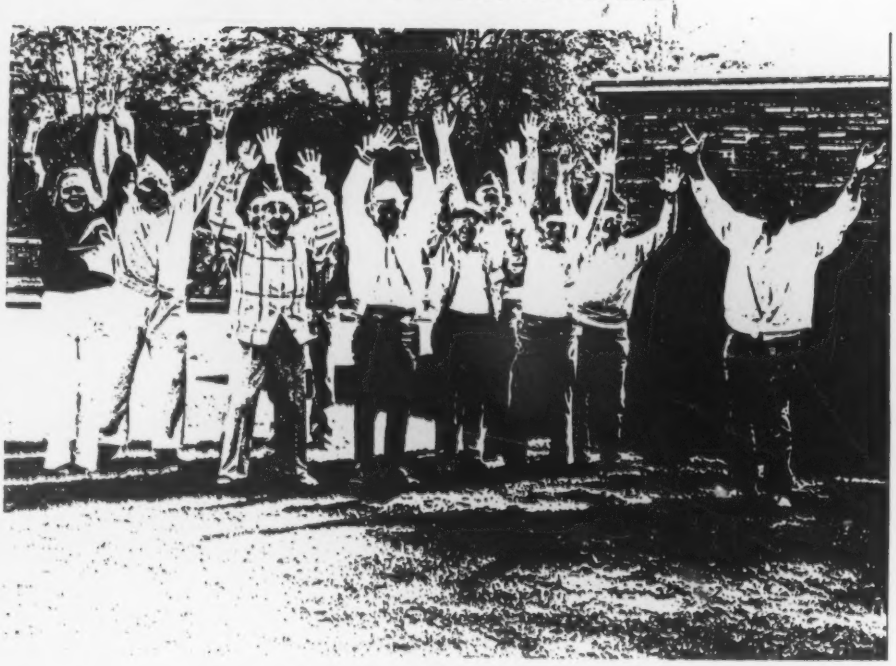
6. Expansion, by new construction, of VA nursing home care beds.

7. Development of innovative ways to care for aging veterans (similar to the DAV/Sepulveda Program).

8. Placing appropriate emphasis on long-term care within the VA system.

Mr. Chairman, this concludes our testimony. We wish to thank you and the members of the Subcommittee for allowing us the opportunity to present the views of the DAV regarding this vital issue and I would be pleased to respond to any questions you may have.

HOME ASSESSMENT PROGRAM FOR SUCCESSFUL AGING



A VOLUNTEER PROGRAM TO IMPROVE THE QUALITY OF LIFE OF VETERANS

DIANA FABACHER, M.S.P.H., Coordinator
GRECC 11E, Sepulveda V.A. Medical Center
16111 Plummer Street, Sepulveda CA 91343

There's no place like home.

HAPSA is Supported by the DAV

TABLE OF CONTENTS

* * * * * * * * *

DAV article on HAPSA 1

Opportunities for Volunteers to Assist Older Adults in the Community 2

Marketing Strategies for Recruitment of Participants and Volunteers 3

Competency Check List for Volunteer Health Screeners 4

Bibliography of Volunteer Programs Applicable to Home Visit Programs 8

"DAV Magazine"

Pilot Project Funded by DAV . . .

Home Visitation Program Launched for Older Vets

A VA pilot project for home visitations of older veterans by volunteers has been launched in the Southern California area.

The project, proposed by Dr. John E. Morley, director of the VA's Geriatric Research, Education and Clinical Center (GRECC) at the Sepulveda VA Medical Center near Los Angeles, is designed for prevention and early detection of diseases in older veterans, as well as the elimination of health hazards in the home.

Dr. Morley, who outlined the project during the VAVS Seminar at the DAV National Convention, said the program is being modeled after a study done in Copenhagen, Denmark, which demonstrated that a structured home visit can improve the care of the elderly.

"I believe it can be a major help, not only in survival of our older veterans, but in their quality of life," he said. "We hope it is the beginning of changing the health care of the elderly in America."

The project is officially called the Home Assessment Program for Successful Aging (HAPSA). "We like to call it, 'happy living,'" Dr. Morley said.

If the three-year pilot project at Sepulveda is successful, the program could be expanded to other VA medical centers throughout the country, requiring the use of thousands of volunteers at these facilities, Dr. Morley said. The pilot project calls for six volunteers, who will be directed by a VA staff Outreach Coordinator.

First-year cost of the pilot project is being provided by the DAV Department of California and DAV Charities of Greater Los Angeles, according to California Department Adjutant Dennis A. Joyner.

"We're very grateful to the DAV," Dr. Morley said. "I think it highlights the success that can be achieved when the VA and service organizations cooperate to bring the veterans the best care possible, especially with such new and innovative programs as this.

"I've always found the DAV incredibly willing to help."

Dr. Morley said the program was officially launched in July, with some visits by VA physicians to the homes of elderly veterans over the age of 75. He emphasized that the program calls for such home visits to be made by volunteers, however.

"This is a volunteer program," Dr. Morley said, indicating that former medical care professionals are needed as volunteers for this pilot home visitation program in the San Fernando Valley area. Such volunteers will receive specialized training from the GRECC staff, and will be provided with structured interview sheets designed to obtain a comprehensive picture of the veteran's physical and mental health, diet, social habits, physical disabilities, and details about the living area.

"Right now, we're also looking for all veterans over 75 in the San Fernando Valley area who are willing to participate in the program," he said. "It's a prevention program, so it's of benefit for all veterans over 75, no matter if they're rich and healthy or poor and sickly."

In addition to the early detection of health problems and the elimination of health hazards in the home, the program will strive to increase awareness of the availability of veterans' health services for those who need them. The veterans will be given packets containing information on veterans' benefits, health promotional materials, services available in the community, nutritional tips, and prevention information.

They also will be given a phone number to call if they have any health questions.

"We want to stop older veterans from having to go to the hospital or into a nursing home," Dr. Morley said.

He emphasized that many ailments that affect older persons can be corrected or treated if caught early enough. He cited Altheimer's Disease, an ailment affecting the memory of older persons. "If we catch it early, it can be treated," he said. "We can save one out of three from this disease."

He said the initial home visits had already found one case of treatable depression, "and the person was not even aware of it." Also, over use of medications can be spotted and corrected. "Medical drugs can be fatal to the elderly," he said.

Physicians and health care professionals from the GRECC at Sepulveda will provide training for the volunteers who make the home calls, and will provide back up services for the veterans needing help. Geriatricians will be available to see all veterans in the program who need their services.

"It is expected that if this pilot program is shown to be effective, it will be easily exportable to the rest of the VA system," Dr. Morley said. "If the program is successful, the GRECC has the resources and expertise to provide national training programs," he added.

Recruiting and training of the staff, identifying the elderly veterans, and follow-up visits to the veterans' homes is scheduled during the first year of the project. Identifying veterans will continue until July 1990. Follow-up visits to the veterans' homes will continue until the end of the pilot project in July 1991. Evaluation of the program will begin midway through the second year, and will continue until July 1991.

Dr. John E. Morley, right, answers questions for a DAV National Convention delegate during the VAVS Seminar.

Unit 41 Wins Award

An error has been noted in the story on the "DAV Auxiliary National Awards," page 25 of the September 1988 issue. In the VAVS Awards category, New Jersey's Joseph McNerney DAV Auxiliary Unit 41 was the winner of the Bea Hogan award for units with 101 to 200 members, not New Jersey's Cape May County Unit 44, as reported in the September story. Our apologies to the members of Auxiliary Unit 41.—The Editors.

Military Mail Call Seeks Help

DAV and Auxiliary units throughout the country can participate in Military Mail Call, an independent, nonprofit activity that provides letters to servicemen throughout the world on special holidays, such as Christmas and Valentines Day.

DAV Auxiliary Unit 4 of Tampa, Fla., was cited as the leading DAV unit nationally last year.

For detailed information on how to be a part of this unique, patriotic program, send your name and address, along with a first-class postage stamp, to: Military Mail Call, P.O. Box 2066, Fort Benning, Ga. 31905.

OPPORTUNITIES FOR VOLUNTEERS TO ASSIST
OLDER ADULTS IN THE COMMUNITY

Friendly Visitor:	Offer companionship, emotional support and friendship to persons with limited social support.
Dial-A-Friend:	Participates in a telephone reassurence program for people who are shut in, or living alone.
Executive Services:	Retired business executives and lawyers provide information on retirement planning. Lawyers can explain living will, durable power of attorney and will execution.
Letter writer:	Volunteer help housebound and visually impaired older adults with correspondence. Screening volunteers may be important if bill paying activies are required.
Reader:	Visit house bound persons to read to them. Also provides large type print books and brings book cassette tapes to those with impaired vision:
Hobby Specialist:	Individual who has expertise in arts and crafts visit homebound to help encourage and teach skills and an arts and crafts activity.
Driver:	Persons with good driving record to provide transportation to doctors offices and other appointments.
Nutrition Aide:	Person to help deliver groceries to isolated individuals to assure that food for an adequate diet is available. The Aide will coordinate with a Program Coordinator or Nutritionist.
Handyman/Handywoman:	Individual to help "injury proof" person's homes, including activities like changing light bulbs, tacking down carpet. Can also help fix leaky faucets and other small repairs.
Yardman/Yardwomen:	Individuals to help tidy yards and mow grass for older adults with limited incomes.
Retired Nurses, Aids, Doctors:	Retired health professional to monitor blood Pressures Aids, and provide patient education. Must work inconjunction with the case manager.

MARKETING STRATEGIES FOR RECRUITMENT

OF PARTICIPANTS AND VOLUNTEERS

1. Letter to all DAV members in target area.
2. Fliers with return card mailed to Information Resource Center's computer generated list (Compensation and Pension files of 70 y/o and older veterans currently not utilizing the V.A.
3. Presentation to Service Groups in target area.
4. Inclusion of the fliers, and adds in Veteran's Service organizations newsletters.
5. Presentation to other community organizations such as religious and non-service groups like the Lion's Club.
6. Radio PSA's.
7. Television PSA's.
8. Feature articles in newspapers.
9. Announcements in AARP, AAA, Chamber of Commerce, and other newsletters.
10. Posters placed in areas visited by Veterans and potential volunteers.
11. Participation in radio and television "magazine hours".

COMPETENCY BASED EVALUATION CHECKLIST

FOR VOLUNTEER HEALTH SCREENERS

Data Base Element	Assessment Competency Volunteer is able to:
Basic Interviewing Skills	1. Use structured interview and assessment instruments
	2. Use appropriate communicative techniques
	3. Demonstrate ability to engage clients
	4. Ask probing type questions
	5. Solicit information in a manner appropriate for the client
	6. Record information that is retrievable
	7. Demonstrate empathy and understanding
	8. Recognize own limitations
	9. Recognize when more assessment is needed
Significant Others Networking	1. Identify significant others
	2. Determine relationships with significant others
	3. Assess and describe clinets' network
Intellectual Functioning	1. Administer mental states exam
	2. Assess literacy skills
	3. Assessability to follow instruction
	4. Assess orientation to time, place and person

Data Base Element	
Living Arrangements	1. Assess home environment for safety and function using environmental survey instrument
	2. Determine if client is satisfied with current living arrangements
Financial Resources	1. Determine if client is knowledgeable about benefits of available programs
	2. Successfully retrieve information regarding adequacy of current resources
Emotional Functioning	1. Use appropriate scales and inventories to assess emotional function
	2. Assess previous and present coping behaviors
Self Care Ability	1. Use a structured ADL and IADL protocol
	2. Identify previous health and social service providers
Rehabilitative Potential and Progress	1. Use structured protocol to determine rehabilitative potential
Lifestyle Behavior	1. Assess adaptive level of occupational, social and leisure time functioning
	2. Take a sexual history
	3. Determine automobile driving patterns
	4. Obtain a chemical history to include misuse and abuse of cigarette, OTC, EHOH, and present prescriptions

Data Base Element	
Lifestyle Behavior (cont'd)	5. Obtain a physical activity history
	6. Assess spiritual, religious and cultural beliefs and their relationship to patient's health and views on health and illness
	7. Obtain current information on the number and level of current activities
Medication History	1. Obtain a comlete medical history including OTC drugs
Medical History	1. Determine and list presenting problems including falls and incontinency
	2. Determine and list history of past problems
Physical Exam	1. Observe and describe mobility
	2. Measure height and weight assess blood pressure using automated blood devise take pulse assess hearing status assess visual status observe and describe deformities or functional impairments
	3. Observe and describe communications capabilities
	4. Observe and describe sensory problems
Oral Assessment and History	1. Perform oral assessment using appropriate technique
	2. Identify past problem
	3. Identify potential problems
	4. Determine personal oral health

practices

Data Base Element	
Oral Assessment and History (cont'd)	5. Determine ability to maintain oral health
Communication Skills	1. Recognize gross auditory and speach functional ability
	2. Recognize environmental interferences including visual factors and auditory factors
	3. Recognize need for environmental modification
	4. Elect Hx of using sensory and communication devices

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HOUSE CALLS

DAV Sponsors Home Visitation Program

The Home Assessment Program for Successful Aging (HAPSA) is a three-year pilot program designed to demonstrate how early disease or illness detection and preventive medicine can successfully lower the cost of improved medical care to older veterans.

Through a series of home visits, HAPSA team members will assess older veterans' health and attempt to preserve or improve their quality of life.

Eligible program participants are those veterans, male and female, at least 70-years-old who have been honorably discharged from the service.

Components of the program include:

- *A medical exam performed by a VA physician or a VA physician's assistant.*
- *If treatment is needed, veterans who meet the VA's eligibility critera will be given appointments at the VA medical center. All other veterans will be advised to seek further medical attention from their personal physician.*
- *Follow-up visits every four months from a volunteer, who is a retired medical professional.*
- *Volunteers to act as friendly visitors and helpers.*

(Continued on page 16)

Meet Bill Brown.

A World War II vet, this retired motion picture camera operator looks and feels much younger than his 79 years. In fact, like many of his contemporaries, Bill feels so good, he hasn't been to a doctor for years.

Meet Bill Brown—a man who may be a walking time bomb.

According to VA Physician's Assistant Fern Pietruska, Bill is a "heart attack or a stroke waiting to happen."

Pietruska, the clinical coordinator for HAPSA who examined Bill, said the results of the tests she performed indicate he has high blood pressure and an extremely high cholesterol count. "A combination that can be deadly."

Like many other older people in seemingly good health, Bill had no idea he was walking a line so close to disaster.

Now, because of HAPSA's early detection of the problem, chances are very good he can be successfully treated. "Within three months, with the proper medication and diet, he should have a significant change for the better in both readings," Pietruska said.

Bill Brown is just one of many examples of how HAPSA's early detection and preventive medicine works to improve the quality of life for older veterans, a quality which can be eroded by depression, memory loss, illness, etc.

In fact, according to one of this country's leading geriatric specialists, most symptoms associated with growing old are actually caused by specific illnesses. They are diseases which can be treated if detected early enough.

Dr. John E. Morley, the director of the VA's Geriatric (GRECC) Research, Education and Clinical Center at the Sepulveda, Calif. VA medical center and designer of the HAPSA pilot, said "In today's society, being old is synonymous with being nonfunctional. I disagree with that, I think most old people are alive, well and doing just great." The goal of HAPSA is to ensure they stay that way.

"These older veterans really are the salt of the earth," Dr. Morely said. "They have given a great deal to this country, but they don't believe this country owes them anything in return.

"HAPSA is not charity, it's a right that these veterans have earned."

Modeled after a successful home visit program in Denmark, HAPSA team members hope to prove that the early detection or prevention of disease will result in lower mortality rates and fewer number of hospital or bed days for older veterans.

According to Dr. Morley, HAPSA, or programs like it, will help to significantly lower the cost of medical care for the elderly. It will do this by reducing the number of serious illnesses and by reducing the necessity for expensive long term care. "We think nothing of spending some $20,000 during the end stage of care to keep someone alive a few extra weeks," Dr. Morley said. "Yet, for just a fraction of that cost we could provide preventive medicine and help a patient live a longer life, a quality life."

The DAV first heard about this innovative new program when Dr. Morley talked about preventive medicine as a guest

VA Physician's Assistant Fern Pietruska, top, takes Bill Brown's blood pressure reading. She will also take his blood pressure while he is sitting and again with him standing. Working from a carefully designed interview sheet, above, Pietruska asks Brown a variety of questions about his physical and mental health.

Edward Haski, top, discusses the different medications he is taking with retired nurse Evelyn Veillette. Sue Aguila, above, a retired nurse, takes Haski's blood pressure. Aguila and Veillette teamed up for their first home visit, later as they gain experience, each nurse will visit veterans on their own.

speaker for the volunteer seminar at the DAV's national convention in Atlanta. "We were impressed by his ideas," said DAV National Director of Voluntary Services Bruce Nitsche. "So impressed, that we asked if we could help.

"We could." One of the foundations of the program is the use of retired medical personnel as volunteers. Making house calls, these volunteers will visit older veterans to perform a medical check up. In addition, other volunteers will help out by becoming friendly visitors or performing handy man chores. "The success of HAPSA largely depends on recruiting and maintaining the right kind of volunteer.

"If this program evolves the way we expect it to, volunteers will eventually be running the program in VA medical centers across the nation," Nitsche said.

The DAV has been able to do more than provide volunteers. It has also provided money to fund the three-year pilot program in California.

The DAV Charities of Greater Los Angeles Inc., has provided $45,000 to HAPSA and the DAV Rehabilitation Foundation has dedicated $25,000 a year for three years.

According to Robert Jordan, a board member of the DAV Rehabilitation Foundation, "The foundation decided to fund this program because they found it to be a unique way to address the very real needs of the older veteran population. We hope our funding will help generate other programs of this nature around the country.

"Personally, I think it's one of the greatest ventures that the DAV can invest in during this time of VA fiscal restraint. We have an opportunity to significantly improve the quality of a veteran's life, at the same time, reduce the cost of his medical care. It's my belief, the government will follow our lead like they have in so many other of our innovative programs," Jordan said.

The pilot program at Sepulveda consists of two phases. Phase one begins with Pietruska, a member of the VA's geriatric staff, visiting a veteran in his or her home. She performs a free health review that includes a battery of tests designed by Dr. Morley and his staff to pinpoint a multitude of problems.

The initial exam includes blood pressure, hearing, eye and body weight tests.

(Continued at page 18)

(Continued from page 17)

dental assessment and blood, urine and stool testing. The veteran is also examined for any indication of neurological or musculoskeletal problems and a detailed list of his eating habits is evaluated. Following the physical portion of the exam a test is given to determine his mental health.

Pietruska also does a walk through of the veteran's home. She looks for health hazards which are usually easily corrected. Small things like scatter rugs, poor housekeeping or overloaded outlets, can pose a serious danger to an older veteran. If needed, she'll help arrange for Meals on Wheels, a handrail in the bathroom, help shopping, or whatever that particular vet needs.

Another part of her job is to stay on top of all the programs and benefits available to an older veteran. Before she leaves, she will give the veteran a packet of information on veterans' benefits, health promotional materials, services available in the community, nutritional tips, prevention information and a list of phone numbers for the veteran to call if he has any health questions.

Once all the lab results are in, Pietruska contacts the veteran to appraise him of the results of her initial assessment. If she feels a problem exists, she advises the veteran to seek care from his personal physician or helps him get an appointment with the VA medical facility if he is eligible for VA health care.

Once the initial assessment has been made by Pietruska, phase two, or the volunteer stage of HAPSA, takes over the patient's case. Follow-up visits are made by retired medical personnel volunteers to see how he's doing.

Every four months these volunteers will visit the patient. Working from a structured interview sheet and a computer print out of that individual's medical history, they will determine if the initial advice and medical recommendations were followed or if any new problems have developed.

In addition, they will help educate the veteran. For example, if a person is diagnosed as having diabetes, the retired medical professional can help teach the veteran about foot care and proper diet.

These volunteers go through extensive training by VA staff before making their first house call. Since they are retired health professionals, much of the training is simply a refresher course. But a lot of new information is given to them which centers on problems specific to geriatric care.

In addition to retired medical personnel, HAPSA also uses volunteers to serve as friendly visitors or perform minor handy work around a veteran's home.

Prior to making any house calls, retired nurses and doctors, top, attend a refresher training course, taught by VA personnel. As a part of their training, the volunteers practice taking blood pressure readings. The training also includes how to recognize the signs of depression and how to communicate with patients who have a hearing loss.

All in all, HAPSA is a program made up of a variety of individuals working together to help veterans. To help coordinate all their activities, the DAV has funded a position at the VA medical center for a Joint Sepulveda VA Medical Center and DAV Pilot Project HAPSA Coordinator. As coordinator, Diana Fabacher is responsible for all aspects of the planning, coordinating and collating of research data for the program. She also overseas the budget and evaluates the project's progress.

According to Dr. Morley much of the credit for getting HAPSA off the ground goes to Fabacher.

Another large part of her responsibilities include the recruiting and training of retired medical professionals to act as volunteers and to coordinating their activities.

Fabacher joined HAPSA from the Mississippi Geriatric Education Center of the University of Mississippi Medical Center where she was the assistant director for program development and evaluation.

"I can't stress enough the importance of our volunteers," she said. "This is essential-

Case Histories

To date, HAPSA has visited approximately 20 veterans in their homes. The following are just a small sample of the people they've met—and helped:

Case one is a 78-year old retired independent contractor currently undergoing medication treatment for depression. Initial assessment by HAPSA showed he still showed signs of depression. In addition, it was noted he had a gait disorder and moderate hearing deficit. Evaluation of his medication schedule revealed he was taking incorrect dosages of his antidepressant. Subsequently he was seen by the staff at the Sepulveda VA medical center's Geriatric Clinic and is undergoing evaluation for his problems.

Case two is a 73-year-old veteran who believed himself to be in good health. Positive findings from lab tests showed a serum cholesterol count that was high and blood in his stool. In addition, the physical exam determined the presence of a high frequency hearing loss and a slightly high blood pressure. The most striking find however, was his low body weight. Six feet, eight inches tall, he weighed only 140 pounds, or 86 percent of his ideal body weight. He is currently undergoing a complete evaluation to determine the cause of his weight loss.

Case three is a 76-year-old veteran who was determined to be too sick to participate in HAPSA. A recruiting phone call discovered he was suffering from amyotropic lateral sclerosis, a disease resulting in progressive deterioration of the nervous and muscular system. He required round the clock nursing care and his wife was no longer able to afford a full-time nurse or meet the physical demands to adequately care for him. Based on HAPSA's recommendations, he was admitted to the VA nursing home for evaluation and to provide respite care for his wife.

Volunteer Exemplifies HAPSA

The dictionary defines a volunteer as a person who offers to do something of his own free will. But according to Diana Fabacher, coordinator of the DAV-sponsored Home Assessment Program for Successful Aging (HAPSA), Sepulveda, Calif., a volunteer is much more than that. It's someone who has the gift of giving. Someone like Frank Lenihan.

"The success or failure home visitation programs like HAPSA rests with our volunteers. If I had an army of people like Frank, I could guarantee our success," Fabacher said.

A DAV life member of Chapter 40, Lenihan volunteers to work between four and eight hours twice a week on Sepulveda's geriatric ward. There he helps shave and bathe patients, empty bedpans, change beds, whatever needs doing. Or he acts as a friend, someone to talk to, to listen and to comfort.

"The patients all seem to take to me pretty quick. I know I take to them. These are a wonderful group of people," Lenihan said.

The hours Lenihan piles up working at the VA hospital doesn't even begin to cover the extent of his volunteer efforts, he also spends a great deal of time visiting and helping house bound veterans.

Lenihan, who lost his left hand, and most of the fingers on his right, in an industrial accident, visits home bound patients to help them with shaving, bathing and simple chores, such as shopping. He also works with his patients to teach them how to take care of themselves. "Many times, it's simply a matter of learning a new way to do an old familiar task. I can show them ways to compensate for their disabilities," Lenihan said. "Sometimes, I just drop by to visit. These are wonderful people and they need a friend."

Walter Jones, 84, is one of three home bound veterans that Frank Lenihan visits everyday to assist with personal hygiene and minor chores.

Currently Lenihan visits three house bound veterans. Spending at least two hours a day with each patient, he said, "I couldn't do this without the support of my chapter. I may be spending the time, but my chapter helps out by defraying the cost of groceries and my gas."

Lenihan, is also quick to point out that he's not the only volunteer in the area making home visits. "There's a lot of us out here helping. The unfortunate part is that there's a need for our help at all. It's unbelievable how many truly sad stories there are right here in our own community," Lenihan said.

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ly a volunteer program, without their help it will never work."

Fabacher is referring to the help of people like Evelyn Veillette, a retired VA nurse who was an Army nurse during during World War II. Veillette said she joined HAPSA's team of volunteers because "This is an excellent program. Too many older people don't take proper care of themselves. They don't watch what they eat or they don't exercise enough. If I can provide that little extra prod they need, I will.

"I know as the programs grows, it will find even more volunteers. Already several of my retired friends have expressed an interest."

Fabacher said she has been pleasantly surprised by both the number of volunteers who are willing to help and with how accepting veterans have been about letting HAPSA volunteers into their homes.

According to Mark Neder, the general manager of the DAV's Charities of the Greater Los Angels, Inc., it's because HAPSA does go into the veteran's home—pays a house call if you will—that it deserves all the support it has been given. "Unlike so many other programs, HAPSA uses its time and energy to go out in the field. It doesn't wait for the veteran to come to the VA for help.

"In addition, this program benefits everyone involved. The VA benefits because it's able to save money, at the sametime provide better medical care by keeping people out of the hospital.

"And most importantly, the veteran benefits. We have helped to maintain his quality of life."

STATEMENT OF
GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR
FOR GOVERNMENT RELATIONS
PARALYZED VETERANS OF AMERICA
BEFORE THE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
ISSUES RELATING TO OLDER VETERANS
APRIL 13, 1989

Mr. Chairman, and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to present our views on issues related to the Department of Veterans Affairs (DVA) ability to meet the expected increase in demand for health care services for aging veterans.

As you know, in the year 2,000, the veteran population over the age 65 will exceed 9 million veterans. The DVA, in our opinion is entirely ill-equipped to meet the growing health care needs of this aging veteran population. The DVA finds itself in a fiscal crisis. As PVA has testified on numerous occasions, this condition is attributable to chronic under funding and unrealistic assessments of demand which have gone unchecked for the past several years. The testimony provided by VA Medical Center Directors and upper level medical system managers last September, 1988, before the House and Senate Committees on Veterans' Affairs, graphically, indicated the unprecedented nature of this problem.

Years of budget shortfalls have cut into the bone of the system's present ability to maintain the appropriate bed levels, staffing levels, and timeliness in the provision of essential medical services. Shortened durations of nursing home contracts, potential closure of VA hospitals, delayed planning for hospital construction, relacement and renovation all contribute to our concerns. Again, by the year 2000 the veteran population, over the age 65, will dramatically increase from 7.2 million in 1990 to 9 million. In the year 1980, there were only 3.0 million veterans over the age of 65. The DVA reported this data in 1980 and completed their study on aging veterans in 1984. Since then, little effort has been directed towards initiating a provisional plan that addresses the problem. Instead, their vision has become blurred and veterans' eligibility for DVA health care has been reduced or curtailed.

What is happening to the DVA health care system is not apparent to the casual observer. But it is obvious to poor, if not impoverished, and/or uninsured and aged veterans, who by the thousands are losing or may lose access to health care. Those veterans losing access to services are veterans who have no alternative to the DVA - those who are chronically ill and need medical monitoring, outpatient care, nursing home care, domiciliary care, respite care, prescriptions, supplies and prosthetic equipment.

The DVA, last September, admitted a funding shortfall for this fiscal year in excess of $600 million. We estimate this shortfall to be in excess of $1 billion when counting the cost of deferred purchases of updated medical equipment for the system. But, if this shortfall does exist, which it does by the Agency's own admission, how can they say that they are adequately meeting true and current service levels to provide adequate care for all eligible veterans? The answer is they cannot. And, in our opinion, they are not providing that care. Outright denial of care is illegal and cannot be tolerated. Intentional delay or restriction of services due to inadequate resources is much more insidious; it is outright dangerous - life-threatening.

Continuing shortfalls in funding have resulted in the inability to recruit needed staff and the closure of thousands of beds. Expensive medical care, such as hip replacements are being denied eligible veterans. Outpatient care has been reduced and rationed in instances where a follow-up outpatient visit is obviously needed. Such instances seriously endanger the present and future health of the aging veteran patient and all veterans.

What can be positively said about the future when budget proposals have, over the last few years, demonstrated complete failure on the part of the Office of Management and Budget to recognize and admit the true needs of the DVA and the veteran population it serves. In fact, it is OMB's fiscal strangulation of the system which has created the crisis the DVA is experiencing at the present time. OMB budget proposals are made by accountants, setting dollar targets in complete disregard of the advice and recommendations of the health care professionals and health care planners in the DVA at all levels of the system, who knows what the Veterans Health Services and Research Administration (VHS&RA) needs to meet current and projected workloads. The DVA spends millions of dollars on planning - a projected $40 million is to be spent on the new Facilities Development Planning (FDP) Process designed to project future construction needs. But, of what use is all this effort and expenditure if OMB does not provide adequate resources to pay for these items?

In their desire to "shrink" the DVA health care system OMB completely forgets that veterans do not stop becoming ill, incapacitated or disabled merely because the DVA does not have the resources or facilities to provide health care for them. A "reduced" DVA provides no cost savings, but only cost shifts as veterans, mostly needy and indigent veterans, are forced to seek care from other federal, state or private health care providers. The sad factor in this scenario was revealed in PVA's recent study "VA Health Care: Actions and Interactions." In many instances these other sources of care are not able to absorb this increased demand - a veteran must then go without proper health care. Such a situation reflects a total abdication of responsibility by government.

ACCESS BARRIERS IMPACT QUALITY

The DVA health care system has always been distinguished for offering patients a comprehensive, coordinated continuum of care. However, as entitlement and eligibility rules now stand under PL 100-272 and PL 100-322 many veterans in Category A, with clear entitlement to inpatient care, are not entitled to outpatient care except in the following circumstances: (1) for service connected disabilities, for veterans with 50 percent or more service-connection, or those disabled by DVA treatment or while in vocational rehabilitation and (2) for certain categories to prepare for or obviate the need for inpatient care. Discussions with top management officials across the VA health care system indicate that the majority of DVA medical centers are greatly reducing access to ambulatory care by restrictive use of the "obviate the need" clause. This is a dollar-driven decision made irrespective of a physician's professional judgement.

Some hospital managers stated that because of inadequate resources, non-service connected medically indigent veterans are provided ambulatory care only in acute emergencies. Basing a decision to provide or deny medical care on a variable and financially motivated interpretation of "obviating the need" leads to poor management of chronic illness--which requires regular periodic care. It is bad medicine -- and often bad economics -- to turn away veterans needing outpatient care on the grounds that their current condition is not sufficiently severe to require hospitalization. It invites acute, serious, and costly complications. It is also a contradiction of the current emphasis on noninstitutional care and preventative medicine.

An even greater magnitude of denial of access to DVA health care for nonservice-connected (NSC) medically indigent veterans will occur under the September 1988 announced CMD policy to be made operational for lack of an early FY 1989 supplemental appropriation. This policy is one of several provisions purported to address a serious shortfall in the FY 1989 medical care budget. Predicated on the rationale of equity in resource distribution, the volume of "discretionary" medical care in any DM&S district will be capped at a percentage of total workload to match that percent of discretionary care found to be the lowest in any DVA Region. Once that assigned cap in discretionary medical care is reached in any given facility, excess funds will be withdrawn, presumably for redistribution to other accounts/medical centers.

Meanwhile, several DVA medical facilities have publicly announced the discontinuance of all care for Category B and C veterans as defined in Public Law 99-272, an option we feel is in marked variance with congressional intent.

Needy veterans turned away from the DVA because of its tight restrictions on ambulatory care are likely to have no alternatives to the DVA care they are denied other than Medicaid, and males under age 65 generally are not eligible for Medicaid no matter how poor they are. Thus, these veterans are likely to add to the uncompensated care burden that private providers are increasingly shunning, or to fail entirely to obtain care when it is needed. (The Medicaid patient, incidentally, is provided ambulatory care regardless of the likelihood of hospitalization, an arrangement certainly more cost effective than inviting, through patient neglect, a crises need for acute inpatient care.)

As identified in a survey PVA conducted in 1988 and substantiated by subsequent surveys of all DVA hospitals by the House Veterans' Affairs Committee and by surveys conducted by Veterans' Service Organizations, wholesale restrictions on needed medical care for both entitled and eligible patients were evidenced throughout the DVA system. Hearings by both Veterans' Affairs Committees in Congress addressed this issue on September 7 and 9, 1988, leading to charges that the DVA had not been accurately identifying its true budgetary requirements over a period of years and had been accommodating resource short-falls by reprogramming funds from such other accounts as equipment, facility activations, and building maintenance and repair, and even resorting to closure of beds and denying or delaying patients' access to all or certain types of care. Aggravating the dollar short-falls is the increasingly serious staffing shortage of nurses and other allied health personnel in many VA hospitals.

CONSTRUCTION

The construction needs of the DVA for maintenance, repair and replacement of facilities are perhaps the most visible indicator of the desperate condition the DVA is in. Quality modern health-care demands an up-to-date and state-of-the-art setting, particularly to care for an aging patient population.

DVA health care facilities are aging at a far greater rate than the veteran population itself. Funding for both major and minor construction has not kept pace with this deterioration. This continuing erosion severely restricts the quantity of health care available and severely endangers the quality of medical services provided to the veteran community. Overall, the DVA's construction program is faced with the following problems.

- The VA has turned a blind eye to the crucial long term care needs of the aging veteran population. The agency restricts funding for home health care alternatives on the one hand and proposes no new nursing home construction for next year on the other. Proper plans to convert existing unused hospital beds to nursing care beds are more promises than reality in this budget as in past budgets. The VA does not even call for the funds to activate the new nursing homes that are coming on line this year.

- The agency's construction priorities are basically dollar driven and dollar restricted without regard to any proper long-term planning process.

- There is no sound, effective or utilitarian process for proper facility development and improvement. The proposed DVA Facility Development Planning process costing at DVA estimates a minimum of $40 million to implement over the next several years is severely flawed. The Medical District Initiated Planning Process (MEDIPP) is unwieldy and awkward, failing to give accurate projections of national VA needs.

- The DVA's Office of Facilities supports a staff of approximately 800 employees and yet major construction projects typically take 10 years from conception to completion. Comparable projects in the private sector take three to four years to complete.

- There has been a systematic history of major errors and flaws in the construction process at great expense to the taxpayer and inconvenience to the veteran. Without adequate or consistent planning, millions of dollars have been spent to design buildings never built or to redesign facilities based on erratic utilization data or ever-tightening budget squeezes.

- The current Office of Management and Budget (OMB) policy only allows the VA to contract for two major clinical additions, replacements, or top-to-bottom renovations per year. At this rate, the VA is on an 86-year replacement cycle for its 172 hospitals.

The DVA is requesting $480,448 million in major and minor construction for FY 1990. The major construction proposal, $365.849 million, is virtually identical to this year's funding level and $37 million below FY 1988 spending. The FY 1990 minor construction appropriation request, $114.699 million, is practically at the same level as FY 1988 and FY 1989. Proposed outlays for minor construction would drop $31.415 million if this budget is approved. We find these funding levels wholly inadequate to meet the needs of the DVA system.

PVA has endorsed construction funding levels proposed by the "Independent Budget By Veterans for Veterans' Programs." The Independent Budget recommendation calls for total major and minor construction appropriations of approximately $922 million. This amount incorporates all of the construction needs projected for FY 1990 by the DVA in its current Five-Year Medical Facility Development Plan. This budget figure is not only our recommendation. It is the projection by the DVA itself of its own construction priorities. The plan details the urgent need to upgrade and improve scores of DVA facilities to meet function and space requirements dictated by modern medical practice.

MILITARY BASE CLOSURES - A POTENTIAL VA RESOURCE

Last Fall, the Congress approved S. 2749, now law, which established a commission to review all military facilities and recommend, based on certain criteria, which facilities could be excessed or closed as a cost-saving measure. The Commission submitted its report on December 31, 1988. The report identified 145 installations, including 86 for closure, 5 for partial closure and 54 others for realignment.

The DVA, by law, already has an established, and growing, relationship with the Department of Defense (DOD), sharing facilities, services and emergency preparedness strategies. As the Congress reviews the Base Closing Commission's report, PVA recommends that the House and Senate Veterans' Affairs Committees look closely at those facilities designated for realignment of mission or closing to determine their feasibility as a possible resource for the DVA.

In certain parts of the country, the DVA is currently facing an alarming increase in demand which is overpowering the ability of existing physical space and facilities to adequately meet that demand. Construction dollars for the DVA are always in limited supply. Even if the dollars are provided for the expansion or modernization of facilities, it currently takes the DVA 10 years to plan, design and construct a major clinical addition, or similar project. A close examination of the "Base Closure" list very well could identify certain facilities in proximity to existing DVA facilities, which could be utilized to augment and improve health care delivery: outpatient clinics, nursing homes, adult day care centers, benefit delivery, or even general office space. A similar review might also identify excess DOD property which could be available to expand the DVA's cemetery system.

PVA sees the potential availability of excess DOD land and facilities as a major resource for the DVA. These facilities could be adapted for cooperative arrangements, not only with the Department of Defense, but with other federal agencies as well. We would be willing to work closely with the House and Senate Veterans' Affairs Committees to review and develop this proposal.

FUNDING FOR VA RESEARCH PROGRAMS

The DVA's research program is a vital ingredient in the agency's health care delivery system. The DVA's contribution to medical science, through its research activity, is well documented.

As PVA's membership ages and the entire patient clientele of the VA grows older, the DVA must maintain adequate levels of research funding for projects which can be directly related to the needs of this population. Advances in medical techniques and breakthroughs in biomedical, prosthetics and rehabilitation technology are, and should continue to be, directly focused on the on-going care of these veterans for the benefit of the individual and the advancement of research itself.

The Reagan Administration proposed to cut FY 1990 funding for medical and prosthetic research from a level of $210 million in FY 1989 to $197 million - a reduction of $13 million. Even a freeze at FY 1989 levels, as proposed by the Bush Budget would seriously injure the DVA's research capability. Many projects and programs already authorized by the Congress and approved by the DVA would still remain unfunded. It is also wholly impractical to have such wild fluctuations in research funding from one year to the next, as many worthwhile research projects rely on multi-year funding. Budget continuity in this respect is essential for a well-coordinated and effective research program.

If caring for the aging veteran population is truly a priority for the DVA, then research emphasis should reflect this priority, noting the needs of the DVA patient population. Even President Bush in his Budget Report to Congress noted the significance and cost effectiveness of coordinated and expanded programs of aging research. He said:

> "We should try to reduce the need for care by devoting significant research attention to the prevention and cure of debilitating illness - illnesses like Alzheimer's, arthritis, and osteoporosis - that can keep us from caring for ourselves."
>
> President George Bush
> Budget Report to Congress, 2/9/89

The DVA has an important role to play in this field. The President's Budget earmarks significant increases in funding for the National Institutes of Health (NIH) and other federal research entities. Yet, when it comes to aging research, the DVA's budget is to be reduced. This does not make sense. The DVA, and the nation as a whole, are facing a major crisis in providing and paying for long term care programs for citizens who are growing older and staying older longer. The most effective way to improve the quality of life for older Americans, and to control the rapidly rising health care costs of an aging population, is to invest in research to prevent or cure afflictions of old age.

For example, an estimated 2.4 million older Americans suffer from Alzheimer's Disease, at a total cost to society of at least $90 billion annually. While scientists have begun to unravel some of the mysteries surrounding this disease, the federal investment in research still amounts to less than $48 per person - compared to $18,000 spent each year to care for each Alzheimer victim. Again, the DVA has an important responsibility in this research field and in the entire arena of aging research. And yet, the DVA is spending a smaller percentage of its total reserch dollar on aging research than it was two years ago. More can and should be done.

The timetable with respect to GRECC's has slipped. The agency currently has 10 operating Geriatric Research, Education and Clinical Centers (GRECCs). The Congress has provided authorization for 25 GRECCs. The VA itself has approved two new GRECCs, one in San Antonio, Texas, and the other in Ann Arbor, Michigan. Because of the funding shortfall, these new programs have not been established. In one center located at a Spinal Cord Injury Center to be determined has not been indicated.

Last year, the Senate Veterans' Affairs Committee, at PVA's recommendation since 1984, authorized the DVA to designate one existing GRECC to provide a specialty with an emphasis in aging with a spinal cord injury and other catastrophic disabilities. On April 1, 1988, the Chief Medical Director of the VA notified PVA that the Agency had plans to fund this project. However, to date the DVA has not gone forward to establish this modest, but clearly important, initiative.

Increased funding for research to cure or ameliorate conditions relating to the aging process promotes independence. An investment in independence

avoids the even higher astronomical costs of long-term institutionalization and long-term chronic care.

Mr. Chairman, in conclusion, the Department of Veterans Affairs is faced with a great opportunity in meeting the challenge of caring for the older veteran. First, the Department has been charged with providing compassionate quality medical services for a senior generation of veterans who, in many instances, would have no other alternative for health care. Second, the cohort of former service personnel from the World War II and Korean War eras, currently entering the DVA system today are on the bow wave of the millions of older Americans who will be seeking acute care and long term care services from our national health care systems in the years to come.

How we deal with this dilemma, now, within the context of DVA health care will certainly contribute to, and be an indicator of, the manner in which we care for the millions of senior American who are living longer and requiring health services longer than at any time in history. The DVA can be on the frontline of this health care onslaught in developing the research tools, case management skills and innovative treatment methods to create a well-designed blueprint for the rest of the Nation to follow later on; or, we can watch the Department sit on its hands. If that happens we not only have failed in our responsibility to meet the needs of the veteran population; but we have also missed a prime opportunity to advance the cause of medical science for the benefit of our society as a whole.

Mr. Chairman, this concludes our testimony. I will be happy to respond to any questions you might have.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 12 1989

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Department's responses to questions raised by Representatives Lane Evans and Bob Stump, following the April 13, 1989, hearing on Issues Related to Older Veterans. A copy of these responses has been provided to Representatives Evans and Stump.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosure

cc: Honorable Lane Evans
Honorable Bob Stump

CONGRESSMAN EVANS

Question: 1. Of the veterans aged 65 or older who have been denied nursing home care this fiscal year, how many are in Category A, Category B and Category C?

Answer: We do not maintain the requested information regarding the number of veterans aged 65 or older who applied, but were not provided, VA nursing home care and VA contract nursing home care during this fiscal year. The actual admission data, however, for the first quarters of each of Fiscal Years 1988 and 1989 is provided below. We estimate that slightly less than one-half of the "Difference" numbers are comprised of veterans aged 65 or older.

CATEGORY	FY 1988	FY 1989	DIFFERENCE
Contract Nursing Home	7,460	5,636	-1,824
VA Nursing Home Care	3,810	3,697	- 113

The VA's best estimate to date of all veterans seen for VA health care is that approximately 93 percent are in the Category A eligibility group; the remaining 7 percent are in the Category B and C groups.

Question: 2. How many VA Nursing Home beds are not being used today because of budgetary reasons?

Answer: The number of nursing home beds not in use for budgetary reasons is 218. These beds are located at Ann Arbor, MI (20); Chillicothe, OH (26); Gainesville, FL (30); Little Rock, AR (10); San Diego, CA (30); Seattle, WA (30); Sepulveda, CA (42); and Syracuse, NY (30).

Question: 3. According to Dr. Winship's testimony, the Department estimates 290,000 veterans will need nursing home care in the year 2000 and the Department aims to serve 16 percent of these veterans.

3A. If the Department provides nursing home care to 16 percent of the veterans in need of care, which veterans will be served by the Department and which veterans will not be served by the Department?

Answer: Veterans considered for nursing home care must first have their eligibility determined. Then, their admission to a nursing home should be in accordance with the priorities established by the Chief Medical Director. A nursing home's turnover rate will influence when and if, a veteran is given access to nursing home care.

Question: 3B. What percent of veterans in need of nursing home care received that care from the Department in 1980 and 1985

Answer: Sixteen percent of all veterans in need of nursing home care received that care through one of the three VA-sponsored programs in 1980; in 1985, the percentage was 18.4.

Question: 3C. How many veterans are estimated by the Department to need nursing home care in 1990, 2010 and 2020 and what percent of these veterans does the Department aim to serve?

Answer: The Department estimates that 183,150 veterans will need nursing home care in 1990; 367,975 veterans will need nursing home care in 2010; and 350,489 veterans will need nursing home care in 2020. The Department plans to care for 16.6 percent of these veterans in one of the three VA-sponsored programs in 1990. The Department's long range plan is to provide care to 16 percent of all veterans needing this level of care in 2010 and 2020.

CONGRESSMAN EVANS

Question: 3D. How many veterans are estimated by the Department to need other forms of extended care in 2000, 2010, and 2020 and how many of these veterans does the Department aim to serve?

Answer: For the noninstitutional care programs, the Department has not found a satisfactory instrument to predict the need for these programs, primarily Hospital Based Home Care (HBHC) and Adult Day Health Care (ADHC). By law and/or policy, both programs are designed to assist discharge planners in making more appropriate long-term care placements following an episode of acute care. For planning purposes, the Department has developed these programs at medical centers where there was evidence of a critical volume of discharges of elderly patients with certain diagnoses and disability levels within reachable geographic boundaries. A primary concern in establishing these programs has been the establishment and maintenance of a sufficient workload of appropriate patients to ensure efficient program operation. In the case of ADHC, VA has also moved cautiously because of the research project which is examining the medical efficacy and cost-effectiveness of ADHC as a substitute for nursing home care.

In the Domiciliary Care Program, the Department has recently instituted a new needs assessment model to measure the need for this level of care. The results of the first application of the model are expected this summer. The Department will be in a better position to project the need for domiciliary care following an analysis of the model's application.

Question: 4. In 1984, the VA issued the following policy statement on providing care to older veterans:

> "The VA will assure that all eligible veterans who seek health care, whether eligibility is based on service-connected disability, age, or other criteria, will have access to high-quality care appropriate to their medical condition, their social situation, and their age."

Is providing nursing home care to 16% of the veterans who need this care consistent with this policy?

Has this policy changed? If so, when did it change and what is the current policy?

Answer: The Department has never planned to provide nursing home care to all veterans in need of this level of care. Rather, the Department has always planned to provide this care to a certain percentage of veterans, based on eligibility and admission priorities.

Since the Department began planning in earnest for the nursing home care needs of a growing aging veteran population in the early 1980's, the Department has planned to treat 16 percent of all veterans needing this level of care.

Question: 5. Please provide and explain the position of the Department on the establishment of a formal geriatric component (GRECC, Assistant Chief of Staff for Geriatrics, GEU, etc.) at each medical center.

Answer: VHS&RA's strategy has been to encourage medical centers to identify a staff position to coordinate geriatric and extended care programs at the local level. For the larger medical centers, the Associate Chief of Staff for Extended Care is seen as the position most suited to this coordinating role. In the case of smaller medical centers, a non-physician allied health professional may be assigned as a "Geriatrics/Extended Care Coordinator."

CONGRESSMAN EVANS

Question: 6. Are veterans in need of extended care being institutionalized unnecessarily and to what extent does this occur?

Answer: In 1984, the Department initiated a Resource Utilization Group (RUGS I) reimbursement model for the long-term care programs (Nursing Home Care and Intermediate Medicine). In 1986, the model was refined and is currently referred to as RUGS II. Soon after the first model was initiated medical center staff determined that some patients were receiving care in the long-term care programs that were not in need of that level of care and an appropriate discharge was initiated. At this time, data received from the medical centers indicate that the vast majority of long-term care patients are in need of the level of care that is being provided.

Question: 7. According to the testimony submitted by Dr. Winship, the benefits of geriatric evaluation units are numerous. Why are there only 87 medical centers with a GEU? In 1984, the VA proposed to have GEUs in 70% of the medical centers by 1990. Will this objective be achieved? In 1984, the Department also proposed establishing, by 2000, a GEU at each medical center. If the Department does not intend to establish a GEU at each medical center by 2000, please explain.

Answer: Historically, GEUs have been funded through local medical center resources. Central Office encouraged and assisted the development of GEUs by funding training conferences. These conferences were aimed at staff who had just started a GEU or who planned to start a GEU within 12 months. The conferences provided training on the mission of GEUs, various models and how to establish a GEU. Approximately 20 stations would attend these conferences and about 15 stations would then develop, and have offically designated, a GEU.

As resources have become more limited, medical centers have found it increasingly difficult to implement new initiatives. Central Office has been unable to fund any GEU training conferences since 1986. As a result, it is unlikely that the objective of having GEUs in 70% of the medical centers by 1990 will be achieved. We are still committed to the establishment of an identified geriatric assessment program in each medical center but are experiencing difficulty in maintaining our originally established time schedule.

Question: 8. What is the plan of the Department to provide institutional and non-institutional extended care to older veterans?

Answer: VA's plans to meet the long-term care needs of aging veterans involve both institutional and noninstitutional programs.

In nursing home care, the Department plans to care for 16 percent of the estimated 290,411 veterans who will need nursing home care in the year 2000. The Department plans to deliver this care to 46,466 veterans on any given day (census or ADC) through the three VA-sponsored nursing home programs: VA Nursing Home Care Units (VANHCU); Community Nursing Homes (CNH); and State Nursing Homes. It is the Department's plan to provide care to 30 percent of the veterans in VANHCUs (13,940 ADC); 40 percent of the veterans will be treated in the CNH Program (18,586 ADC); and 30 percent of the veterans needing nursing home care will be treated in the State Home Program (13,940 ADC).

Through Fiscal Year 1988, VA had already reached 70 percent of its year 2000 goal for nursing home care. VANHCUs had reached 81 percent of its workload goal; the CNH Program had reached 67 percent of its goal; and the State Nursing Home Program had reached 62 percent of its year 2000 goal.

CONGRESSMAN EVANS

In the Domiciliary Care Program, the Department has recently instituted a new needs assessment model to measure the need for this level of care. The results of the first application of the model are expected this summer. The Department will be in a better position to project the need for domiciliary care following the analysis of the model's application.

In noninstitutional care, the Department has supported those programs that emphasize the medical and health care needs of patients. Since 1985, the Department has expanded Hospital Based Home Care from 50 medical centers to 73 medical centers. In that same time period, the Agency has established 15 VA-operated Adult Day Health Care Programs and has granted contracting authority to 22 VAMCs for these services, which have resulted in 68 contracts. The keys to the existence and expansion of these programs is their potential for substitution for institutional care; their ability to assist the host medical center in discharge planning; and their ability to provide quality services. The Department will continue to search for and test new modalities of care which meet these criteria, although there do not appear to be any new approaches on the horizon at this time.

Question: 9. What is the plan of the Department to utilize throughout the Department's health care system the lessons which have been learned from the GRECC program?

Answer: The Department is in the process of developing a plan to expand the mission of the GRECCs in order to enhance their impact on the Department's entire health care system. The Department is seeking the expert advice of the Geriatrics and Gerontology Advisory Committee in developing this plan.

Question: 10. How many GRECCs should be established? How many medical centers have submitted a GRECC proposal? How many proposals are pending? How many GRECCs has the Chief Medical Director recommended be established?

Answer: VA plans to expand the GRECC program within the authorized limit of 25 centers. Effective this fiscal year, the process for a medical center to submit a proposal for a new GRECC has been integrated with MEDIPP (Medical District Initiated Program Planning). This fiscal year's MEDIPP cycle is not completed and at this time the number of medical centers that will express the desire to compete for a GRECC is not known. Based on inquiries and the fact that 11 medical centers submitted proposals during the last GRECC solicitation, we anticipate receiving up to 15 new proposals. At this time we have no pending GRECC proposals but we do have two recently designated GRECCs. Once these two new GRECCs are fully operational, there will be a total of 12 GRECCs.

Question: 11. Are hospital care and ambulatory care given a higher priority by the Department than extended care?

Answer: Hospital and outpatient care are given a higher priority than nursing home care because of the legislative mandate to provide this care to certain categories of veterans.

CONGRESSMAN EVANS

Question: 12. Dr. Winship's testimony refers to the critical importance of disseminating information on GRECC activities. How can the dissemination of information on GRECC activities be improved? How many or what percent of department health care providers have attended or participated in continuing education programs presented by GRECCs? How does the Department intend to increase the accessibility to and utilization of GRECCs by other VA medical centers?

Answer: Currently information on GRECC activities is disseminated via traditional methods. Research findings are disseminated through publications in professional journals and books, presentations at scientific and clinical meetings and meetings of journal clubs. Research findings are also disseminated through fellowship training programs with a research component. Educational activities of the GRECCs are disseminated through published conference proceedings, audio and video tapes and publications. Each year the GRECCs plan and implement a total of about 15 major continuing education programs. In FY 1988, funds were provided for approximately 1,300 health care professionals from VA medical centers throughout the system to attend these conferences. In addition, GRECCs hold regular continuing education programs for staff at their local VA medical centers throughout each year. Dissemination of clinical programs developed by GRECCs is through clinical training of physicians, nurses and other health care professionals and consultation by GRECC staff at other VA medical centers. Through participation in work groups, the research and clinical expertise of GRECC staff is frequently brought to bear on the development of system-wide guidelines, policies and informational bulletins.

The Department is developing a strategy to achieve the goal of improved dissemination of GRECC information. A key factor in the strategy is the importance that has been given to this goal by the Assistant Chief Medical Director for Geriatrics and Extended Care. Emphasis will also be placed on more sharing between the GRECCs and other VA programs, such as Regional Medical Education Centers and Cooperative Health Manpower Education Programs, as well as sharing between the GRECCs and other Federal government sponsored programs, such as the Public Health Service's Geriatric Education Centers. GRECCs will be encouraged to develop medical district networks and to take the initiative in developing consultation and continuing education programs to meet their district's needs. The Ann Arbor GRECC proposes to develop and evaluate such a model which has the potential to be exported to other GRECCs. The role of new technologies such as satellite teleconferencing will be explored. Lastly, GRECC management staff will be involved in developing new ways to achieve this goal.

Question: 13. In 1984, the VA projected a need for from $7 to $25 billion in new construction and expansion of facilities primarily between 1990 and the year 2000 to provide care for the older veteran. This construction was to be in addition to $1 billion in construction per year needed for modernization and replacement. If this projection of construction needed to provide care to older veterans is not accurate today, please provide the current projection. What additional Department facilities are expected to be needed to provide care to older veterans?

Answer: The 1984 estimate of need of between $7 to $25 billion in construction funding to provide care for older veterans was referenced in the Department of Veterans Affairs report, "Caring For The Older Veteran." The funding range identified was considered the maximum amount estimated to be required to meet a specific set of planning assumptions and a specific construction strategy for meeting VA needs outlined in the report.

CONGRESSMAN EVANS

The report acknowledges that specific requirements for new or expanded programs and facilities to provide for the older veteran will be determined by the Department through its ongoing detailed planning efforts. Consequently the $7 to $25 billion estimate should be viewed only as a then current (1984), tentative assessment of projected need. The estimate should not be construed to be either part of a final construction plan or a budget document.

Over time changes reflected in VA's detailed planning efforts, including refinements in planning processes, changes in program policies and economic conditions have indeed occurred and have had an affect on the estimate identified in the 1984 report. In addition, since 1984 several of the assumptions made in preparing the cost estimate cited in the report have not been borne out, so that there is a further affect on the 1984 estimate. Included among the changing assumptions are (1) that VA would be responsible for a 40% share of the program mix for long term care beds, (2) that expansion of the domiciliary program would follow a specifically identified course and, (3) that a specific funding level in the construction budget authority would be provided.

VA's current assessment of construction needed to provide for care for the older veteran to the year 2000 includes approximately $630 million (current dollars) for nursing home and domiciliary care and approximately $2.6 billion (current dollars) for clinical improvement and replacement/modernization projects which may include programs to care for the older veteran. Those programs include hospital based home care (HBHC); respite care; adult day health care (ADHC); geriatric research, education and clinical centers (GRECC); geriatric evaluation units (GEU); and, outpatient treatment services. VA will continue to assess and refine the planning for programs and resources needed to provide care to the older veteran. Construction ultimately proposed to Congress for funding will also continue to reflect the needs of the older veteran within the overall constraints of the Department's program and budget policy guidance.

Question: 14. Why does the Office of Geriatrics and Extended Care have only 17 FTEE?

Answer: There are 18 FTEE authorized for the Office of Geriatrics and Extended Care; there is currently one vacancy which will be filled as soon as possible. The office was recently cut one FTEE to help fill Congressionally mandated needs.

Question: 15. What percent of the total DVA research budget is used for aging research? Is the percent of research devoted to aging commensurate with the percent of elderly veterans? Please describe current plans to increase the amount and percent of geriatrics and gerontology research.

Answer: In responding to the first question it is important to note that two categories of research may be considered relevant to aging (a) research directed to achieving an increased understanding of the aging process, and (b) research concerned with understanding, preventing, diagnosing, and treating diseases that are highly prevalent among elderly patients. Approximately $15,090,676 or 7.5 percent of the R&D budget is allocated to support studies in the first catergory; approximately $77,651,000 or 39 percent, in the second category. Thus a total of $92,741,676 or 46.5 per cent of the R&D budget is directed to "aging studies".

CONGRESSMAN EVANS

Beyond recognizing that research in aging is an important area for VA, no explicit effort is made to align research expenditures with number of patients or veterans in the upper age brackets. We believe that other factors such as the state of knowledge in the field, the methodological feasibility of given types of research and the availability of research-trained investigators who can develop meritorious studies are the key determinants in the number of studies supported in any given area.

At the moment, with the sharp reductions in the R&D budget, we are unable to consider increasing research on aging or in any other areas. We do believe, however, that the statistics presented above indicate that R&D is already making a substantial commitment to aging research.

Question: 16. What percent of total medical-dental residency training positions are devoted to geriatrics? Please describe current plans to increase the number of medical-dental traineeships in geriatrics as well as the number of allied health traineeships?

Answer: In 1989, nearly two percent of the 8,350 medical resident positions are dedicated to geriatric medicine. These 153 positions are providing about 1,500 one to two month rotations to residents training in general internal medicine, family practice, neurology, or psychiatry.

In addition, upper level resident positions provide 2-year fellowships to 65 board eligible or board certified physicians per year. After more than a decade of support, 206 fellows have completed this special training, and about 90 percent continue to practice geriatric medicine in the VA, the affiliated medical schools, and the non-government sector. The Department of Veterans Affairs' fellowships constitute the largest single training pool for geriatric medicine in the nation. This strong support led to the ultimate recognition of geriatric medicine by the American Board of Internal Medicine and the American Board of Family Practice in 1988. Henceforth, any VA medical center may request extra positions for geriatrics, provided they are accredited as a training site by the ACGME (Accreditation Council for Graduate Medical Education). The size of future increases will depend on accreditation status and on the budget.

In 1989, none of the 354 dental resident positions provide rotations for geriatrics. However, since 1982, the Department of Veterans Affairs has offered 10 special fellowships per year for geriatric dentistry. As of June 1989, 30 dentist fellows have completed special training and most are serving in academically oriented positions. Through their teaching and research activities, these fellows influence the dental health care of elderly patients far beyond the VA health care system. Beginning in 1989, the number of training sites increased from 5 to 6.

Associated health trainees in geriatrics have been supported in VA since FY 1980. Student funding and positions have increased from $80,000 and 17 positions for FY 1980 to $2,088,000 and 414 positions in FY 1989. Any further increase will depend on additional budget support.

CONGRESSMAN EVANS

Question: 17. What percent of regional and national training programs sponsored by RMECs are devoted to geriatrics? Please describe current plans to increase geriatric training and education for VA staff in the field.

Answer: In support of the VA's mission to provide health care to the aging veteran population, education and training continues to be a priority to enhance VA medical center (VAMC) staff skills in the area of geriatrics. These educational activities are designed to respond to the needs of VA health care personnel throughout the Veterans Health Services & Research Administration.

In FY 1988, the Regional Medical Education Centers (RMECs) sponsored 166 continuing education activities, training 7000 individuals on the topic of geriatrics. This represents approximately 6% of all RMEC-sponsored training programs, and 8% of all VA participants trained for FY 1988. While firm figures are not yet available for the first half of FY 1989, our preliminary data indicates that the RMECs have sponsored a minimum of 22 activities, training almost 2000 participants. Examples of recent programs include:

- o Working Effectively with Elders and Their Families;
- o Geriatric Assessment: The Team Approach;
- o Clinical Geriatrics: Strategies for Quality Care;
- o Communication Disorders in the Elderly;
- o Physiological Changes of Aging; and
- o Gerontology: Challenges, Changes, Commitments.

In FY 1988, "Health Care Problems of the Elderly," was identified as one of 14 National Training Program priorities in the VA. This multi-year program will provide systemwide training to all VA facilities concerning the special health care needs of the elderly.

Continuing Education funds are provided to each of the VAMCs to meet the continuing education needs of its employees. Approximately $137,000 of facility-directed monies supported training activities in geriatrics in FY 1988. VACO also allocates funds for VAMC-initiated programs to allow health care facilities, with assistance from a RMEC, to conduct education programs at the medical center to meet locally identified training needs. Approximately $17,000 of VAMC-Initiated funds were used to support these activities in FY 1988.

RMEC programs are also conducted in cooperation with the Geriatric Research, Education, and Clinical Centers (GRECCs) which received $158,000 in Postgraduate and Inservice Training (PIT) funds to support their identified training needs. This collaborative effort ensures the efficient use of existing resources to meet the increasing demand for training in geriatrics.

The Office of Academic Affairs (OAA) sets training priorities based on input from VACO and field program officials and data collected from annual RMEC needs assessment surveys. As needs are identified and priorities are established, OAA will allocate the appropriate amount of resources to accomplish the goal.

Question: 18. According to the prepared testimony of Dave Gorman, DAV, the Department is considering leasing to a private nursing home the recently closed Nursing Home Care Unit of the Syracuse VAMC. Please provide the applicable policy of the Department, describe all expected benefits to veterans including any preference for care, and state the total number of Medical Center Nursing Home Care Unit beds which are currently being leased to private nursing homes.

Answer: The idea of renting the recently closed Nursing Home Care Unit (NHCU), at VAMC Syracuse to a private nursing home, was proposed to Medical Center Management in mid-February; by Mr. Normal Andrzejewski, Area Administrator, Office of Health Systems

CONGRESSMAN EVANS

Management, State of New York. This proposal was presented as a temporary solution to the community's need for nursing home care beds. Longer term solutions to this problem, i.e., the construction of additional beds, are in progress.

Center Management took this proposal under advisement and informed Mr. Andrzejewski that the following actions would have to be taken prior to any decision being made: VA's legal authority would have to be reviewed, the matter would be discussed with VA Central Office and the input of appropriate congressional representatives and Veterans Service Organizations would have to be obtained. Mr. Andrzejewski was further informed, that if the responses to the above-cited items was favorable, other conditions would have to be met, and that, if and when appropriate VA funding became available, the contractor would have to vacate the premises at the earliest possible date, as the NHCU would be reopended. The reaction to this proposal was uniformly negative and all consideration of the idea was dropped by the VA.

Question: 19. Please provide information on the major accomplishments of the GRECC program in terms of education, research and clinical care.

Answer: GRECCs disseminate geriatric and gerontological knowledge through continuing education activities and through the provision of training to Geriatric Fellows, residents, nurses and other associated health trainees. The 179 graduates of VA's Geriatric Physician Fellowship Program (approximately 50 percent of whom were trained at GRECC sites) represent the largest single agency contribution to the development of geriatric medicine as a recognized area of special competence in the United States. In addition to fellowship training, the GRECCs provide geriatric training to more than 600 medical, dental and allied health trainees annually.

Regarding continuing education, GRECCs frequently co-sponsor their programs with the affiliated university to broaden the target audience to include both VA and community health care providers. In addition to continuing education conferences, GRECC staff provide lectures, seminars, case conferences and teaching clinical rounds at their local VA medical centers as well as lectures and training at other VA medical centers and the community. On an annual basis, the GRECC staff at the 10 sites have provided over 5,000 educational activities for practitioners within their local VA medical centers, more than 1,000 lectures at academic and professional meetings and more than 500 training sessions at other VA medical centers and community settings. The GRECCs have also produced educational materials that can be utilized by practitioners throughout the VA. A few examples of these include a publication entitled Cancer Pain developed by the Durham GRECC, a series of 21 Dementia Caregiver Education Pamphlets produced by the Minneapolis GRECC, 3 videotape programs dealing with management of Alzheimer's disease developed by the Bedford division of the Boston GRECC and 2 booklets published by the Sepulveda GRECC which concentrate on practical tips intended to reduce need for hospital care by encouraging preventive, self-help measures ("80 Do's and 58 Dont's for Your Safety" and "Fourteen Fountains of Youth").

CONGRESSMAN EVANS

GRECC reseachers are recognized nationally and internationally for their achievements. The GRECC program boasts researchers who number among the top 5 in their specialty areas. GRECC researchers not only receive recognition for their accomplishments through publications in prestigious, peer-reviewed journals, but also through invitations to serve on peer-review panels of the National Institutes of Health, receipt of national research awards, acceptance of papers at national and international conventions and election to offices of national aging organizations.

The following selected examples highlight the scope and range of GRECC research influence on the provision of care to elderly persons:

- Dr. Reaven's (Palo Alto GRECC) research on diabetes and aging has found that glucose intolerance commonly associated with aging does not occur in individuals who remain physically active. This finding offers hope that changes in life style by middle-age and elderly individuals may prevent adult-onset diabetes.

- Drs. Larry Thompson and Dolores Gallagher (Palo Alto GRECC) are finding that depressed elderly patients who cannot take antidepressants due to side effects of medication or who choose not to take medication may still experience symptomatic relief through psychotherapy.

- Dr. Daniel Everitt (Boston GRECC) and his colleagues have shown excessive psychoactive drug use in nursing homes. They have designed an educational program to address this problem and are now analyzing data to determine the effectiveness of this intervention.

- Dr. Takashi Makinodan and his colleagues (West Los Angeles GRECC) are investigating ways to rejuvenate the immune responses of the elderly. This work is encouraging by suggesting it may well be possible to significantly reduce the acute and chronic catastrophic illnesses facing the elderly through the restoration of their immune functions to those of a younger adult.

- Dr. Thomas Lampe (Seattle GRECC), in collaboration with Dr. Thomas Bird (Seattle VA Medical Center), has published in Science (241:1507-1510, 1988) findings that are important for researchers attempting to identify the gene responsible for Alzheimer's disease. They have discovered that in ten families suffering from familial Alzheimer's disease (the "Volga Germans"), an autosomal dominant gene could be identified but, unlike reports from other families, it did not map to chromosome 21.

The single most important clinical achievement of the GRECCs has been the development of a geriatric evaluation and treatment program. The first Geriatric Evaluation Units (GEUs) were established as clinical demonstration models. In a landmark randomized controlled study done at the Sepulveda GRECC and published in the New England Journal of Medicine in 1984, the GEU was found highly successful in improving patient care outcomes (including decreased mortality, decreased discharge to nursing homes, lower rehospitaliztion rates and lower cost of care) over a one year follow-up. This model of care has now been replicated in 87 VA medical centers and in private sector hospitals. Other clinical demonstration programs developed by GRECCs include dementia study units, academic nursing homes, and multiple, specialized outpatient programs such as clinics for elderly patients with cancer, osteoporosis, falls and sleep disorders and a sheltered workshop for dementia patients.

CONGRESSMAN EVANS

Question: 20. How many veterans will need domiciliary care in 2000, 2010 and 2020 according to Department projections?

Answer: The Department has recently instituted a new needs assessment model to measure the need for domiciliary care. The results of the first application of the model are expected this summer. The Department will be in a better position to project the need for domiciliary care following an analysis of the model's application.

Question: 21. To what extent are the extended care needs of older veterans not being met by the Department today?

Answer: The Department provides health care services to eligible veterans. These services include acute hospital care; outpatient care; and an array of extended care programs from hospital-based nursing home care to adult day health care. The Department does not provide or pay for health-related and social support programs. These programs include homemaker services; chore services; and home-delivered meals. The Department recognizes that these services are beneficial, however, delivery of these services by VA are beyond the statutory mission of the Department. However, VA Social Service staffs provide ongoing referral services to community agencies which do provide these services at minimal costs to the veteran.

Question: 22. Please identify the VA Medical Centers at which hospital beds are planned to be converted to nursing home care beds during fiscal years 1989 and 1990 and provide the total beds to be converted at each medical center.

Answer: Listed below are the medical centers and the number of hospital beds which are planned to be converted to nursing home beds in Fiscal Years 1989 and 1990:

FY 1989

Medical Center	Beds	
Ft. Meade, SD	60	
White River Jct., VT	-15	
Altoona, PA	14	(Reactivation)
Brockton, MA	31	
Knoxville, IA	60	
Waco, TX	76	
Biloxi, MS	28	
Grand Island, NE	34	
St. Cloud, MN	96	
Total	384	

FY 1990

Medical Center	Beds
Buffalo, NY	34
Leavenworth, KS	75
Roseburg, OR	30
Walla Walla, WA	30
Chillicothe, OH	82
Ft. Lyon, CO	37
Total	288

CONGRESSMEN EVANS

Question: 23. In a letter to Jack Powell of PVA dated April 12, 1988, Dr. Gronvall stated that a GRECC research program would be expanded to include the study of special problems of aging with a long-term disability such as spinal cord injury. When and at which GRECC or GRECCs will this research program expansion occur?

Answer: Proposals for this project have been received from 4 GRECCs and have been reviewed by a panel of VA and non-VA experts in spinal cord injury and long term care. Although the final decision as to which proposal will be funded has not been made, the expansion dollars will go to one of the following GRECCs: Boston, St. Louis, Little Rock or Seattle. Funding of this project will depend upon VA's FY 1990 appropriation, but we are hopeful that action can be taken during FY 1990.

Question: 24. According to the Testimony of Dr. Winship, during Fiscal Year 1989, approximately 325 beds will be converted to nursing home care beds from another kind of care. How many nursing home care beds have been closed or taken out of use during Fiscal Year 1989? Please compare the number of nursing home care beds which have been closed or taken out of service during Fiscal Year 1989 to the number of beds expected to be converted to Nursing Home Care this fiscal year.

Answer: During FY 1989, 218 beds have been taken out of use. The current planned conversion to nursing home beds is 384.

CONGRESSMAN STUMP

Question: 1. How many health professionals participated in continuing education programs sponsored by, and held at, Geriatric Research, Eudcation and Clinical Centers in fiscal year 1988?

Answer: On an annual basis, the GRECC staff at the 10 sites have provided over 5,000 educational activities for practitioners within their host VA medical centers and more than 5u0 training sessions at other VA medical centers and community settings. In fiscal year 1988, the 10 GRECCs sponsored 20 major continuing education programs which were attended by more than 1,300 VA health care professionals throughout the system. These programs were also attended by numerous health care professionals from the community.

Question: 2. Does the DVA expect to increase the number of health professionals participating in GRECC sponsored training and education activities in fiscal year 1989? If so, by now much?

Answer: In fiscal year 1989, the number of VA health care professionals expected to participate in GRECC sponsored continuing education programs is slightly less than in fiscal year 1988, because of a reduction in travel funds.

Question: 3. Conversely, how many GRECC professionals delivered inservice education and dissemination of GRECC related information at DVA facilities in fiscal year 1988?

Answer: Specific data is not collected on the individual GRECC staff who deliver inservice education and dissemination of GRECC related information because all of the professional staff are expected to be involved in these activities. Each GRECC has an Associate Director for Education and Evaluation who has primary responsibility for coordinating all educational activities.

Question: 4. Does the DVA expect to increase the number of inservice educational opportunities held at DVA medical facilities in fiscal year 1989? If so, by how much?

Answer: In FY 1988, there were 172,887 participants at continuing education activities throughout the system and 20,628 participants in the tuition support program. In FY 1989, the continuing education budget is being maintained at current services, therefore participants will remain fairly constant at approximately 173,000. The tuition support program was increased by $5,050,000 and we estimate 38,000 participants in this program.

ANSWERS BY DR. RICHARD C. ADELMAN, CHAIRMAN
GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE
TO QUESTIONS SUBMITTED BY CONGRESSMAN LANE EVANS
OVERSIGHT AND INVESTIGATIONS HEARING
4/13/89

Q1. THE GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE HAS ISSUED A NUMBER OF REPORTS EACH CONTAINING RECOMMENDATIONS TO THE DEPARTMENT. PLEASE DESCRIBE THE RESPONSIVENESS OF THE DEPARTMENT TO THE RECOMMENDATIONS OF THE ADVISORY COMMITTEE.

A1. Careful analysis of the recommendations included in these reports during the past several years and of the Departmental response to those reports justifies the award of mixed grades both to the Department and to the Advisory Committee. There are instances of appropriate and inadequate responses by the Department. At the same time, in my opinion, my predecessors as Chairmen of the Advisory Committee too frequently forwarded overly bland reports and less than specific recommendations.

More to the point, however, is the overall realization that the Department has failed to prepare for the delivery of appropriate care to its rapidly growing population of aging veterans. This unfortunate state of affairs is reflected in each of the following points:

1) The continuing emphasis of the DVA health care system on acute medical problems blatantly ignores the reality that the rapidly growing population of aging veterans requires a shift in emphasis to long term care, to much greater utilization of the other health professions, and to much greater integration into the community-based social service network and family support systems which characterize the non-VA world.

2) There are grossly insufficient numbers of physicians and other health care providers who are trained in geriatrics.

3) The extent of support by the DVA for the pursuit of necessary new knowledge through research on aging does not remotely reflect the very real impact of aging on the present veteran population.

4) Central Office is so insensitive to the magnitude of this problem that it has chosen to reduce drastically the number of nursing home beds; to ignore accomplishments of the GRECCs by the delay of funding for already approved and selected sites, as well as not even to request Congressional appropriations for any of 13 already authorized additional sites; and effectively not to honor recent recruitment promises to the new Assistant Chief Medical Director for Geriatrics and Extended Care by reducing the size of a staff that already is too small.

Each of these issues will be addressed with specific recommendations for action in the pending report of the Geriatrics and Gerontology Advisory Committee, which is to be delivered to the Chief Medical Director and to the House Veterans Affairs Committee in October, 1989.

Q2. PLEASE IDENTIFY EACH GRECC AT WHICH THE ADVISORY COMMITTEE HAS MADE AN ON-SITE EVALUATION. HOW FREQUENTLY SHOULD AN ON-SITE EVALUATION BE MADE OF EACH GRECC BY THE ADVISORY COMMITTEE? WHAT CRITERIA ARE USED FOR GRECC EVALUATIONS AND WHAT ARE THE RESULTS OF THE EVALUATIONS WHICH HAVE BEEN MADE BY THE ADVISORY COMMITTEE?

A2. The Advisory Committee, as well as numerous other review groups appointed by the Department, has made several on-site evaluations at each of the funded GRECCs. The appropriate frequency for on-site evaluation of these kinds of model centers of excellence probably is once every three years; similar to expectations for external review of academic departments or institutes. The criteria used thus far for GRECC evaluations relate primarily to traditional scholarly means of program-specific analysis. For example, for the research component the issues usually focus on quality and quantity of scientific papers published in refereed journals, as well as successful competition for peer-reviewed external grant support. Analogous kinds of criteria are applied to the educational and patient-care components of the GRECCs.

In general, such evaluations have been interpreted appropriately as reflections of satisfactory to exceptional progress in the traditional sense of academic program development, with some GRECCs predictably performing better than others.

Unfortunately, there is not in place a national plan, the purpose of which is to utilize the overall GRECC program as a means to catalyze the infusion of geriatrics into the national mainstream of activity in research, education and patient care more in keeping with the rapidly growing size of the aging veteran population. The absence of such a plan, as late as 15 years following the inception of the GRECC program, is one of the primary reasons that the GRECCs remain so isolated from the mainstream of VA activity. One of the highlights of the pending report of the Geriatrics and Gerontology Advisory Committee, which is to be delivered to the Chief Medical Director and to the House Veterans Affairs Committee by October, 1989 is such a plan.

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

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In Reply Refer To: 181

JUL 1 4 1989

Honorable Lane Evans
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in further response to our testimony of April 13, 1989, before the Subcommittee on Oversight and Investigations concerning the AMVETS/University of Illinois teaching nursing home (TNH) project proposal. The proposal presents a thoughtful and detailed analysis which strongly supports the concept of "reactivation" nursing home care. However we have several concerns about the proposal and the extent of expected VA support. Our most important concerns are threefold in nature.

First, the proposal would have the effect of establishing a two-tiered program of nursing home care for veterans in which a small percentage of veterans with the highest rehabilitation potential would be referred to the TNH for intensive care, consuming approximately 30 percent of community nursing home care funds for the medical district while leaving the bulk of the patients to receive customary care with diminished funds. The second, and related concern is that VA does not have grant funds to underwrite the cost of this project and, in this time of fiscal constraints on the community nursing home and other programs, VA is not prepared to make the requested commitment of $32 million over a period of five years. Third, we are doubtful that Medical District 17 VA medical centers can generate sufficient patients meeting TNH criteria to maintain 70 per cent of the average daily census, or 82 patients.

We remain interested in the concept of "reactivation" nursing care but cannot make the requested fiscal commitment at this time. We will be pleased to refer to the TNH, selected patients who meet established criteria.

We have informed AMVETS/UIC of our concerns and are prepared to discuss them in further detail.

Sincerely yours,

John A. Gronvall, M.D.
Chief Medical Director

"America is #1—Thanks to our Veterans"

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